DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2014

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2014 Congressional Justification for the Health Resources and Services Administration (HRSA). HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. This budget targets critical healthcare needs in underserved areas.

Millions of our fellow Americans will receive access to high quality, comprehensive and cost-effective primary health care through the HRSA funded Health Center program. Additional resources are also being provided for the Ryan White HIV/AIDS program to enhance prevention efforts and treatment for people living with HIV/AIDS. Through the AIDS Drug Assistance Program, life-saving medications will reach approximately 219,000 needy Americans. Increasing collaboration and alignment of programs within HRSA and among our partners expands our capacity and improves our ability to achieve public health goals. Assuring a strong public health and primary care workforce is central to the Nation's health.

HRSA's FY 2014 budget invests resources to increase the number of health care practitioners in areas of the country experiencing shortages. This will help ensure that qualified clinicians will be available to serve underserved populations in the future. The budget also includes $122 million to improve both access to and the quality of health care in rural areas. This will strengthen regional and local partnerships among rural health care providers, expand community-based programs and promote the modernization of the health care infrastructure in rural areas.

Thanks to the Affordable Care Act (ACA), HRSA has an even broader role. Combined with first of its kind initiatives like the National HIV/AIDS strategy, HRSA's mandate continues to grow. Working with our DHHS partners, HRSA is responsible for 50 individual provisions in the health care law. ; These generally fall into three major categories:

- Expanding the primary care safety net for all Americans – especially those who are geographically isolated, economically disadvantaged or medically vulnerable – for example, through expansion of the Health Center program;

- Training the next generation of primary care professionals, while improving the diversity of the workforce and re-orienting it toward interdisciplinary, patient-centered care. HRSA does this through targeted support to students and clinicians and grants to colleges, universities and other training institutions;

- Working with its partner agencies, HRSA is expected to greatly expand prevention and public health efforts to catch patients' health issues early – before they require major intervention; to improve health outcomes and quality of life; and to help contain health care costs in the years ahead.

Our FY 2014 budget request places a strong emphasis on investing in programs that improve access to health care in underserved areas and allows the Health Resources and Services Administration to take important steps toward implementing healthcare reform and improving healthcare access for underserved populations. We are determined to work with our DHHS and other healthcare partners to assure the health of the Nation.

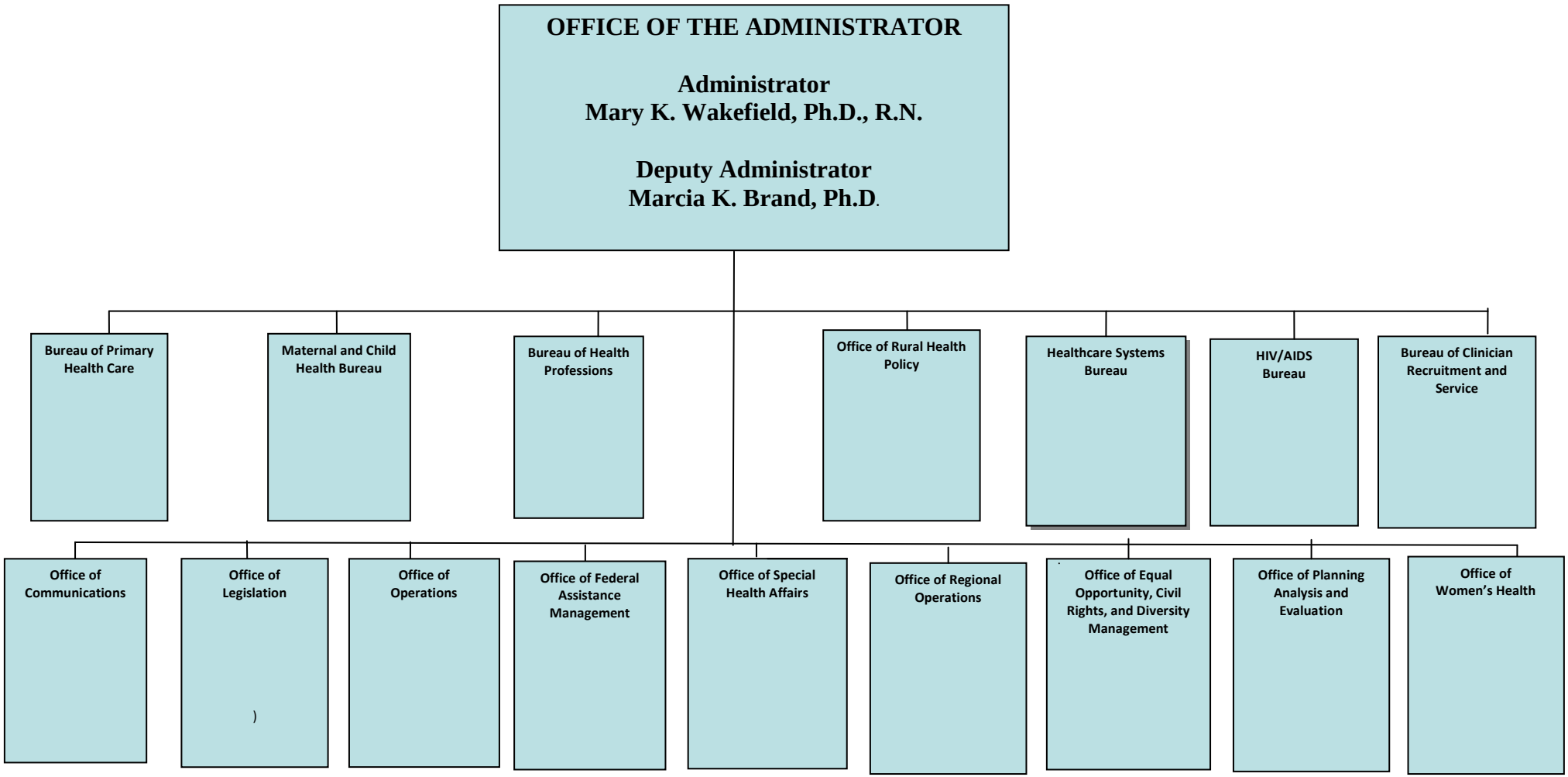
Mary K. Wakefield, Ph.D., R.N.
Administrator

TABLE OF CONTENTS

FY 2014 Budget

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Organizational Chart



Executive Summary

TAB

INTRODUCTION AND MISSION

The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health and Human Services (DHHS), is the principal Federal Agency charged with increasing access to basic health care for those who are medically underserved. Health care in the United States is among the finest in the world but it is not accessible to everyone. Millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language and cultural barriers. The Affordable Care Act provides for substantial expansion of components of the HRSA-supported safety net, including the Health Center Program, the National Health Service Corps, and a variety of health workforce programs, to address these and other access problems. While implementation of health reforms and other factors may affect the structure and function of the safety net, assuring an adequate safety net for individuals and families who live outside the economic and medical mainstream remains a key HRSA role.

HRSA's mission as articulated in its Strategic Plan for 2010-2015 is: To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. HRSA supports programs and services that target, for example:

- The 50 million Americans who lack health insurance--many of whom are racial and ethnic minorities,
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday,
- The more than 1 million people living with HIV/AIDS,
- The more than 100,000 Americans who are waiting for an organ transplant.

Focusing on these and other vulnerable, underserved groups, HRSA's leadership and programs promote the improvements in access, quality and equity that are essential for a healthy nation.

Overview of Budget Request

The FY 2014 President's program level request of $9 billion for the Health Resources and Services Administration is a net increase of $841 million above the comparably adjusted FY 2012 enacted level.[1] HRSA is the principal Federal agency charged with improving access to health care to those in medically underserved areas and enhancing the capacity of the health care workforce. The FY 2014 Budget prioritizes programs that will:

- Reduce barriers to care that contribute to disparities in health care utilization and health status;
- Provide healthcare to uninsured people by linking people to services and supports from other sectors that contribute to good health and wellbeing;
- Provide financial, professional and educational resources to medical, dental, and mental and behavioral health care providers who bring their skills to areas with limited access to health care; and
- Assist States and communities to identify and address unmet service needs and workforce gaps in the health care system.

Discretionary Program Increases:

Pediatric Loan Repayment (+$5 million)
The FY 2014 President's Budget request include $5 million to provide loan repayment to individuals in return for delivering pediatric services in areas requiring such services. An estimated 64 2-year awards will be made across the eligible specialties in the first year of implementation.

HIV/AIDS Comprehensive Care, Part B (+$10 million)
The FY 2014 President's Budget Request includes $943,299,000 for AIDS drug assistance programs (ADAP) to provide access to life saving HIV related medications. The FY 2014 target is 218,942. This represents an increase of 1,618 clients served given a budget increase of $10,000,000 over the FY 2012 Enacted Level for ADAP. This significant federal investment will provide increased access to lifesaving pharmaceuticals for people living with HIV/AIDS eligible for ADAP.

HIV/AIDS Early Intervention, Part C (+$10 million)
The FY 2014 President's Budget Request for the Ryan White HIV/AIDS Part C Program of $225,086,000 is $10,000,000 above the FY 2012 Enacted Level. This request will support persons receiving primary care services under the Early Intervention Services programs for almost 269,000 PLWHA at the 357 currently funded Part C grantees.

[1] The comparably adjusted level does not include the Health Education Assistance Loan program (HEAL), which is proposed to be transferred to the Department of Education in FY 2014.

Organ Transplantation ($+2 million)
The FY 2014 Request will continue support for the Organ Transplantation Program in achieving the FY 2014 performance targets: transplant over 25,000 deceased donor organs and achieve over 4,400 expected life-years gained for the five-year post-transplant period for kidney and kidney/pancreas transplants performed.

340B Drug Pricing Program/Office of Pharmacy Affairs User Fees (+$6 million)
This reflects the estimate amount of user fees. These funds will be used to enhance oversight of the 340B Drug Pricing Program.

Program Management (+$1.9 million)
This increase supports increased funding for salaries, benefits and IT expenses.

Family Planning (+$33.5 million)
This request provides services to nearly 5 million persons, with approximately 90 percent having family incomes at or below 200 percent of the poverty level.

Discretionary Program decreases:

Health Professions Programs -$39.6 million
This request includes $4.8M from the Prevention and Public Health fund for Public Health and Preventative Medicine. The FY 2014 request provides funding for an initiative that, when sustained over five years, will increase the primary care workforce by 2,800 primary care providers (1,400 primary care PAs, and 1,400 advanced practice registered nurses (APRNs). No funds are requested for the Health Careers Opportunity Program and the Area Health Education Centers.

Children's Hospital Graduate Medical Education Program (-$177.2 million)
This request of $88 million is about one-third of the FY 2012 Enacted Level, which will allow for support of the direct portion of medical expenses for graduate medical education for all participants that are currently in the program. These include direct payment support expenditures related to stipends and fringe benefits for residents; salaries and fringe benefits of supervising faculty; costs associated with providing the GME training program; and allocated institutional overhead costs.

James T. Walsh Universal Newborn Hearing (-$18.7 million)
Funding for this program is requested from the Prevention and Public Health Fund at $18.7 million.

Heritable Disorders (-$9.8 million)
Funding for this program is requested from the Prevention and Public Health Fund at $9.8 million.

Poison Control (-$18.8 million)
Funding for this program is requested from the Prevention and Public Health Fund at $18.8 million.

Rural Hospital Flexibility Grants (-$14.8 million)
The reduction would result in discontinuation of new grants in FY 2014 for the Small Hospital Improvement Program (SHIP). The budget request focuses on supporting CAHs by maintaining essential support for the Flex program and its focus on working with CAHs to improve quality. The program will award 48 grants in FY 2014.

Rural and Community Access to Emergency Devices (-$1.1 million)
No funding is requested for this program.

Mandatory Program Increases:

Health Centers (ACA) (+$1 billion)
This increase will promote steady and sustainable Health Center growth beyond FY 2015 when ACA mandatory funding expires. The ACA funds complement funds the program receives annually in the discretionary budget process. The Budget will enable health centers to continue to provide critical access and services to 22.6 million patients in FY 2014.

National Health Service Corps (ACA) (+$10 million)
This program is funded from the Affordable Care Act in FY 2014. Funding will support over 200 new scholarships and scholarship continuations, over 2,300 new loan repayment awards, over 2,100 loan repayment continuations, 100 new Students to Service loan repayment awards, and 285 new State loan repayment awards.

Maternal, Infant, and Early Childhood Visiting Program (+$50 billion)
This program is funded from the Affordable Care Act in FY 2014. Funding will support awards to 53 State and territory grantees and three non-profit organizations, 24 to 26 awards to American Indian tribes, and $13 million for research, evaluation, and corrective action technical assistance for States not meeting benchmarks.

Mandatory Program decreases:

School Based Health Centers (ACA) (-$50 million)
The Affordable Care Act appropriated $200 million over FY 2010-FY 2013 for School Based Health Centers. The No funds are being requested for this program in FY 2014.

Family to Family Health Information Centers (-$5 million)
The American Taxpayer Relief Act of 2012 appropriated $5 million for this activity in FY2013. No funds are being requested for this program in FY 2014.

Overview of Performance

This Performance Budget documents the progress HRSA has made and expects to make in meeting the needs of uninsured and medically underserved individuals, special needs populations, and many other Americans. HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing that vision, HRSA's strategic goals are to: improve access to quality health care and services, strengthen the health workforce, build healthy communities, and improve health equity. The performance and expectations for HRSA programs are highlighted below as these relate to HRSA goals and HHS strategic objectives, indicating the close alignment of specific programmatic activities and objectives with broader HRSA and Departmental priorities. The examples illustrate ways HRSA helps states, communities and organizations provide essential health care and related services to meet critical needs.

Highlights of Performance Results and Targets (Planning Level)

HRSA Goals: Improve access to quality health care and services; Improve health equity
HHS Objectives: Ensure access to quality, culturally competent care for vulnerable populations; Emphasize primary and preventive care linked with community prevention services.

HRSA programs support the direct delivery of health services and health system improvements that increase access to health care and help reduce health disparities.

- In FY 2014, the Health Center program projects that it will serve 22.6 million patients. This is an expected increase of 2.4 million over the 20.2 million persons served in FY 2011.

- HRSA expects to serve 31 million children through the Maternal and Child Health Block Grant (Title V) in FY 2014; 38.7 million were served in FY 2011.

- By reaching out to low-income parents to enroll their children in the Children's Health Insurance Program (CHIP) and Medicaid, HRSA improves access to critically important health care. In FY 2014, the number of children receiving Title V services that are enrolled in and have Medicaid and CHIP coverage is expected to be 14 million. In FY 2011, the number was 14.8 million.

- In FY 2014, HRSA's Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 2.6 million visits and 2.2 million visits for health-related care (primary medical, dental, mental health, substance abuse, and home health). Approximately 2.6 million visits and 2.2 million visits, respectively, were supported in FY 2010.

- By supporting AIDS Drug Assistance Program (ADAP) services to an anticipated 218,942 persons in FY 2014, HRSA expects to continue its contribution to reducing AIDS-related mortality through providing drug treatment regimens for low-income, underinsured and uninsured people living with HIV/AIDS. More than 211,000 persons were served through ADAP in FY 2011.

- The number of organ donors and the number of organs transplanted have increased substantially in recent years. In FY 2014, HRSA's Organ Transplantation program projects that 25,014 deceased donor organs will be transplanted, up from 24,973 in FY 2011.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, HRSA's C.W. Bill Young Cell Transplantation program projects that it will have nearly 3.1 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2014. Nearly 2.9 million were listed on the registry in FY 2012.

- In FY 2011, 615,849 persons received direct services through Rural Health Care Services Outreach, Network, and Quality Improvement Grants. The projection for FY 2014 is 400,000.

- In FY 2011, the Black Lung program supported services to more than 12,800 active and retired coal miners with occupation-related respiratory and pulmonary impairments. In FY 2014, an estimated 12,840 miners will be provided diagnostic, treatment and other services provided by Black Lung clinics.

HRSA Goal: Strengthen the health workforce.
HHS Objective: Ensure that the Nation's health care workforce can meet increased demands.

HRSA works to improve health care systems by assuring access to a quality health care workforce in all geographic areas and to all segments of the population through the support of training, recruitment, placement, and retention activities.

- In FY 2012, the National Health Service Corps (NHSC) had a field strength of 9,908 primary care clinicians. The NHSC projects that a field strength of 7,607 primary care clinicians will be in health professional shortage areas in FY 2014.

- In FY 2012, 64% of NURSE Corps (formerly known as the Nursing Education Loan Repayment and Scholarship Program) participants extended their service contracts and committed to work at a critical shortage facility for an additional year. The FY 2014 target is 52%.

- In FY 2012, 7,375 health care providers were deemed eligible for FTCA malpractice coverage through the Free Clinics Medical Malpractice program, which encourages providers to volunteer their time at sponsoring free clinics. The projection for this number is 7,600 in FY 2014.

HRSA Goal: Improve access to quality health care and services.
HHS Objective: Improve health care quality and patient safety.

Virtually all HRSA programs help improve health care quality, including those programs or program components that focus on improving the infrastructure of the health care system.

- In FY 2014, 95.7% of Ryan White program-funded primary care providers will have implemented a quality management program, comparable to the figure in FY 2011.

- In FY 2014, 85% of Critical Access Hospitals (supported by the Rural Hospital Flexibility Grants program) will report at least one quality-related measure to Hospital Compare. This will be an increase from 72.6% in FY 2010.

HRSA Goal: Improve health equity.
HHS Objective: Accelerate the process of scientific discovery to improve patient care.

- The National Hansen's Disease Program seeks to prevent and manage Hansen's disease (leprosy) though both clinical care and scientific research. The Program is conducting research that will ultimately permit development of the full animal model (armadillo) that will advance understanding of the disease in humans. In 2011, the Program used DNA evidence to link leprosy transmission from armadillos to humans. In 2014, the Program will continue to pursue a relevant animal model for human leprosy.

In the ways highlighted above and others, HRSA will continue to strengthen the Nation's healthcare safety net and improve Americans' health, health care, and quality-of-life.

Performance Management

Achieving a high level of performance is a Strategic Plan principle and a major priority for HRSA. Performance management is central to the agency's overall management approach and HRSA routinely uses performance-related information to improve the agency's operations and those of its grantees. HRSA's performance management process has several integrated elements, including priority setting, action planning, and regular monitoring and review with follow-up.

Each year, HRSA sets priorities through the process of establishing performance plans for Senior Executive Service (SES) personnel. This process identifies key goals that are supported, to the greatest extent possible, by quantitative or qualitative measures and targets. Goal leaders plan for the major actions that must be accomplished to achieve goals. Many of the goals are outcome-oriented and their achievement is largely dependent upon the direct actions of grantees, supported by HRSA. Other goals relate to internal processes and organizational functioning that reflect standards for how HRSA does its business.

Performance monitoring is done by:
(a) Assessing achievement of performance measure targets,
(b) Monitoring, through the work of project officers and progress reports, grantees' interim progress and challenges associated with goal achievement, and
(c) Tracking key milestones that indicate, for example, the advancement or completion of major deliverables linked to accomplishment of goals.

Regular reviews of performance occur between goal leaders and the Administrator/Deputy Administrator. These reviews include monthly one-on-one meetings, mid-year and year-end SES performance reviews, and ad hoc meetings called to address emerging issues/problems. The meetings cover progress, successes, challenges, and possible course-corrections. Focused discussions of performance, particularly related to cross-cutting goals, are also held at Senior Staff meetings.

HRSA will continue to produce an Annual Performance Report that will show trends in performance related to priority goals and other goals of HRSA's Bureaus and Offices. The Report, posted on-line, will provide information for performance assessment purposes and also give transparency to HRSA's performance results.

All Purpose Table

(Dollars in Thousands)

Program	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
PRIMARY CARE:				
Health Centers	1,471,999	1,491,943	1,471,999	-
Community Health Center Fund (ACA)	1,200,000	1,500,000	2,200,000	1,000,000
Health Center Tort Claims	94,893	95,474	94,893	-
Total, Health Centers	**2,766,892**	**3,087,417**	**3,766,892**	**1,000,000**
School-Based Health Centers - Facilities (ACA)	50,000	50,000	-	-50,000
Free Clinics Medical Malpractice	40	40	40	-
Subtotal, PL Bureau of Primary Health Care (BPHC)	**2,816,932**	**3,137,457**	**3,766,932**	**950,000**
Subtotal, Mandatory BPHC (non-add)	***1,250,000***	***1,550,000***	***2,200,000***	***950,000***
Subtotal, Discretionary BA BPHC (non-add)	***1,566,932***	***1,587,457***	***1,566,932***	-
HEALTH WORKFORCE:				
CLINICIAN RECRUITMENT & SERVICE				
National Health Service Corps (ACA)	295,000	300,000	305,000	10,000
Total, NHSC	**295,000**	**300,000**	**305,000**	**10,000**
NURSE Corps	83,135	83,644	83,135	-
Loan Repayment/Faculty Fellowships	1,243	1,264	1,243	-
Pediatric Loan Repayment	-	-	5,000	5,000
Subtotal, Clinician Recruitment & Service	**379,378**	**384,908**	**394,378**	**15,000**
HEALTH PROFESSIONS				
Health Professions Training for Diversity:				
Centers of Excellence	22,909	23,049	22,909	-
Scholarships for Disadvantaged Students	47,452	47,742	47,452	-
Health Careers Opportunity Program	14,779	15,064	-	-14,779
Health Professions Training for Diversity	**85,140**	**85,855**	**70,361**	**-14,779**
Health Care Workforce Assessment 1/	2,782	2,827	5,000	2,218
PHS Evaluation Funds (non-add)	-	-	-	-
Primary Care Training and Enhancement	38,962	39,200	50,962	12,000
Oral Health Training Programs	32,392	32,919	32,392	-
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	27,230	30,269	-	-27,230
Geriatric Programs	30,629	31,127	30,629	-
Alzheimers Prevention Fund	2,000	-	5,300	3,300
Subtotal, Geriatric Programs	**32,629**	**31,127**	**35,929**	**3,300**
Mental and Behavioral Health	2,892	2,939	2,892	-
PHS Evaluation Funds (non-add)	-	-	-	-
Mental and Behavioral Health Prevention Fund	10,000	-	-	-10,000
Subtotal, Mental and Behavioral Health	**12,892**	**2,939**	**2,892**	-10,000
Subtotal, Interdisciplinary, Community-Based Linkages	**72,751**	**64,335**	**38,821**	-33,930
Public Health Workforce Development:				
Public Health/Preventive Medicine	8,144	8,243	3,226	-4,918
Public Health/Preventive Medicine Prevention Fund	25,000		4,776	-20,224
Subtotal, Public Health/Prevention Medicine	**33,144**	**8,243**	**8,002**	-25,142
Nursing Workforce Development:				

Health Resources and Services Administration

Program	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Advanced Education Nursing	63,469	64,316	83,469	20,000
PHS Evaluation Funds (non-add)	-	-	-	-
Subtotal, Advanced Education Nursing	**63,469**	**64,316**	**83,469**	**20,000**
Nursing Workforce Diversity	15,819	16,077	15,819	-
Nurse Education, Practice and Retention	39,638	39,820	39,638	-
Nurse Faculty Loan Program	24,553	24,953	24,553	-
Comprehensive Geriatric Education	4,485	4,558	4,485	-
Subtotal, Nursing Workforce Development	**147,964**	**149,724**	**167,964**	**20,000**
Children's Hospitals Graduate Medical Education Program	265,171	269,488	88,000	-177,171
Subtotal, Bureau of Health Professions	**678,306**	**652,591**	**461,502**	**-216,804**
Health Workforce Evaluation Funding	-			
National Practitioner Data Bank (User Fees)	*28,016*	*28,016*	*28,016*	-
Subtotal, PL Health Workforce (BCRS, BHPr)	1,085,700	1,065,515	883,896	-201,804
Subtotal, Discretionary Health Professions (non-add)	*641,306*	*652,591*	*451,426*	*-189,880*
Subtotal, Discretionary Health Workforce (non-add)	*725,684*	*737,499*	*540,804*	*-184,880*
Subtotal, Discretionary Health Workforce (excludes GME)	*460,513*	*468,011*	*452,804*	*-7,709*
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	638,646	649,046	638,646	-
Autism and Other Developmental Disorders	47,142	47,909	47,142	-
Traumatic Brain Injury	9,760	9,919	9,760	-
Sickle Cell Service Demonstrations	4,665	4,741	4,665	-
James T. Walsh Universal Newborn Hearing Screening	18,660	18,963	-	-18,660
James T. Walsh Universal Newborn Hearing Screening Prevention Fund	-	-	18,660	18,660
Subtotal, James T. Walsh Universal Newborn Screening	18,660	18,963	18,660	-
Emergency Medical Services for Children	21,116	21,460	21,116	-
Healthy Start	103,532	105,218	103,532	-
Heritable Disorders	9,834	9,994	-	-9,834
Heritable Disorders Prevention Fund	-	-	9,834	9,834
Subtotal,Heritable Disorders	9,834	9,994	9,834	-
Family to Family Health Information Centers (ACA)	5,000	5,000	-	-5,000
Maternal, Infant and Early Childhood Visiting Program (ACA)	350,000	400,000	400,000	50,000
Subtotal, Maternal and Child Health Bureau	**1,208,355**	**1,272,250**	**1,253,355**	**45,000**
Subtotal, Discretionary MCHB (non add)	*853,355*	*867,250*	*824,861*	*-28,494*
Subtotal, Prevention Fund MCHB (non add)	-	-	*28,494*	*28,494*
Subtotal, Mandatory MCHB (non add)	*355,000*	*405,000*	*400,000*	*45,000*
HIV/AIDS:				
Emergency Relief - Part A	666,071	675,366	666,071	-
Comprehensive Care - Part B	1,360,827	1,328,722	1,370,827	10,000
AIDS Drug Assistance Program (Non-Add)	*933,299*	*903,797*	*943,299*	*10,000*
Early Intervention - Part C	215,086	206,431	225,086	10,000
Children, Youth, Women & Families - Part D	77,167	77,639	77,167	-
AIDS Education and Training Centers - Part F	34,542	34,753	34,542	-
Dental Reimbursement Program Part F	13,485	13,568	13,485	-

Health Resources and Services Administration

Program	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Subtotal, HIV/AIDS	**2,367,178**	**2,336,479**	**2,387,178**	**20,000**
SPNS Evaluation Funding	*25,000*	*25,153*	*25,000*	**-**
Subtotal, HIV/AIDS Bureau	**2,392,178**	**2,361,632**	**2,412,178**	**20,000**
HEALTHCARE SYSTEMS:				
Organ Transplantation	24,015	25,001	26,015	2,000
National Cord Blood Inventory	11,887	11,960	11,887	**-**
C.W. Bill Young Cell Transplantation Program	23,330	23,473	23,330	**-**
Poison Control Centers	18,830	18,945	**-**	-18,830
Poison Control Centers Prevention Fund	**-**	**-**	18,830	18,830
Subtotal, Poison Control	18,830	18,945	18,830	**-**
340b Drug Pricing Program/Office of Pharmacy Affairs	4,472	4,499	4,472	**-**
340b Drug Pricing Program/Office of Pharmacy Affairs User Fees	**-**	**-**	*6,000*	*6,000*
Hansen's Disease Center	16,045	16,143	16,045	**-**
Payment to Hawaii	1,960	1,972	1,960	**-**
National Hansen's Disease Program - Buildings and Facilities	127	130	127	**-**
Subtotal, Healthcare Systems Bureau	**100,666**	**102,123**	**108,666**	**8,000**
Rural Health:				
Rural Health Policy Development	9,866	9,926	9,866	**-**
Rural Health Outreach Grants	55,553	55,893	55,553	**-**
Rural & Community Access to Emergency Devices	1,100	2,511	**-**	-1,100
Rural Hospital Flexibility Grants	41,040	41,291	26,200	-14,840
State Offices of Rural Health	10,036	10,097	10,036	**-**
Radiation Exposure Screening and Education Program	1,935	1,947	1,935	**-**
Black Lung	7,140	7,184	7,140	**-**
Telehealth	11,502	11,572	11,502	**-**
Subtotal, Office of Rural Health Policy	**138,172**	**140,421**	**122,232**	**-15,940**
Program Management	159,894	162,500	161,794	**1,900**
Family Planning	293,870	298,655	327,402	**33,532**
HRS Program Level	**8,195,767**	**8,540,553**	**9,036,455**	**840,688**
Appropriation Table Match	**6,205,751**	**6,232,384**	**6,015,039**	**-190,712**
Less Mandatory Programs	***1,937,000***	***2,255,000***	***2,962,400***	***1,025,400***
Subtotal Affordable Care Act	***1,900,000***	***2,255,000***	***2,905,000***	***1,005,000***
Subtotal Public Health Prevention Fund	***37,000***	**-**	***57,400***	***20,400***
Discretionary Program Level:				
HRS	**6,258,767**	**6,285,553**	**6,074,055**	**-184,712**
Funds Appropriated to Other HRSA Accounts:				
Health Education Assistance Loans:[2]				
Liquidating Account	1,000	1,000	-	-1,000
HEAL Credit Reform - Direct Operations	2,807	2,853	-	-2,807
Subtotal, Health Education Assistance Loans	**3,807**	**3,853**	**-**	**-3,807**

[2] The FY 2014 Budget include a General Provision language that would transfer the Health Education Assistance Loan (HEAL) program to the Department of Education. Funding for the administration of the HEAL program is reflected in the Department of Education.

Health Resources and Services Administration

Program	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	235,000	235,000	235,000	-
VICTF Direct Operations – HRSA	6,477	6,517	6,477	-
Subtotal, Vaccine Injury Compensation	**241,477**	**241,517**	**241,477**	-
Discretionary Program Level:				
HRS	**6,258,767**	**6,285,553**	**6,074,055**	**-184,712**
HEAL Direct Operations	2,807	2,853	-	-2,807
Vaccine Direct Operations	6,477	6,517	6,477	-
Total, HRSA Discretionary Program Level	**6,268,051**	**6,294,923**	**6,080,532**	**-187,519**
Mandatory Programs:	1,937,000	2,255,000	2,962,400	1,025,400
Total, HRSA Program Level	**8,205,051**	**8,549,923**	**9,042,932**	**837,881**
Less Programs Funded from Other Sources Mandatory:				
Prevention and Public Health Fund	*37,000*	-	*-57,400*	*-20,400*
Less Programs Funded from Other Sources:				
Evaluation - Special Projects of National Significance (SPNS)	*-25,000*	*-25,153*	*-25,000*	-
Evaluation - Health Workforce	-	-	-	-
National Practitioner Data Bank (User Fees)	*28,016*	*-28,016*	*-28,016*	-
340b Drug Pricing Program/Office of Pharmacy Affairs (User Fees)	-	-	*-6,000*	*-6,000*
Total HRSA Discretionary Budget Authority	**6,215,035**	**6,241,754**	**6,021,516**	**-193,519**

Health Resources and Services

Budget Exhibit

Appropriation Language

Primary Health Care

For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the ``PHS Act'') with respect to primary health care and the Native Hawaiian Health Care Act of 1988, [$1,579,975,000] *$1,566,932,000* [, of which $127,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center:] *Provided*, That no more than $40,000 shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act, including associated administrative expenses and relevant evaluations: *Provided further*, That no more than $94,893,000 shall be available until expended for carrying out the provisions of Public Law 104-73 and for expenses incurred by the Department of Health and Human Services (referred to in this Act as ``HHS'') pertaining to administrative claims made under such law. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Health Workforce

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, section 1128E and 1921(b) of the Social Security Act, and the Health Care Quality Improvement Act of 1986, [$522,187,000] $*540,804,000*: *Provided*, That sections 747(c)(2), [340G-1(b) and (d)], and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made available under this heading: *Provided further*, That in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under such Act sufficient to recover the full costs of operating the National Practitioner Data Bank and shall remain available until expended to carry out that Act: *Provided further*, That fees collected for the full disclosure of information under the ``Health Care Fraud and Abuse Data Collection Program'', authorized by section 1128E(d)(2) of the Social Security Act, shall be sufficient to recover the full costs of operating the program, and shall remain available until expended to carry out that Act*: Provided further*, That fees collected for the disclosure of information under the information reporting requirement program authorized by section 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the program and shall remain available until expended to carry out that Act: *Provided further*, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such sections: [*Provided further*, That, in addition to amounts appropriated under this heading, $35,000,000 shall be available under section 241 of the PHS Act to carry out titles VII and VIII of the PHS Act:] *Provided further*, That, of the amount appropriated under this heading, $88,000,000 shall be for payments to children's hospitals pursuant to section 340E of the PHS Act, all of which shall be for payments for direct graduate medical education as described in section 340E(c).

Maternal and Child Health

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, title V of the Social Security Act, and section 712 of the American Jobs Creation Act of 2004, [$854,807,000] *$824,861,000*: *Provided*, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than $78,641,000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and $10,276,000 shall be available for projects described in paragraphs (A) through (F) of section 501(a)(3) of such Act.

Ryan White [Hiv/Aids] *HIV/AIDS* Program

For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, [$2,446,772,000] *$2,387,178,000*, of which [$2,093,599,000] *$2,036,898,000* shall remain available to the Secretary through September 30, [2014] 2016, for parts A and B of title XXVI of the PHS Act : *Provided*, That of the funds available for parts A and B of title XXVI of the PHS Act, not less than [$1,000,000,000] *$943,299,000* shall be for State AIDS Drug Assistance Programs pursuant to section 2616 or 311(c) of such Act: *Provided further*, That in addition to amounts provided herein, $25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out parts A, B, C, and D of title XXVI of the PHS Act to fund Special Projects of National Significance under section 2691.

Health Care Systems

For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005,[$82,534,000]: *$83,836,000, of which $127,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center: Provided*, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: *Provided further*, That fees pursuant to the 340B Drug Pricing Program shall be collected by [manufacturers at the time of sale] *the Secretary based on sales data that shall be submitted by drug manufacturers* and shall be credited to this account, to remain available until expended.

Rural Health

For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act, the Cardiac Arrest Survival Act of 2000, and sections 711 and 1820 of the Social Security Act, $122,232,000, of which $26,200,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: *Provided*, That, of the funds made available under this heading for Medicare rural hospital flexibility grants, $1,000,000 shall be to carry out section 1820(g)(6) of the Social Security Act, with funds provided for grants under section 1820(g)(6) available for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs electronic health record system: *Provided further*, That notwithstanding section 338J(k) of the PHS Act, $10,036,000 shall be available for State Offices of Rural Health.

Family Planning

For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, [$296,838,000] $*327,402,000*: *Provided,* That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

Program Management

For program support in the Health Resources and Services Administration, [$162,517,000] $*161,794,000*: *Provided,* That funds made available under this heading may be used to supplement program support funding provided under the headings ``Primary Health Care", ``Health Workforce", ``Maternal and Child Health", ``Ryan White HIV/AIDS Program", ``Health Care Systems", and ``Rural Health": *Provided further,* That the Administrator may transfer funds between any of the accounts of HRSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the ``PHS Act'') with respect to primary health care and the Native Hawaiian Health Care Act of 1988, [$1,579,975,000] *$1,566,932,000* [of which $127,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center:]	Citation is deleted to reflect HRSA's reorganization. Under the reorganization, Hansen's Disease Program is now part of the Health Care Systems Bureau. This also requires a change in the appropriations language. HRSA proposes administering and managing the functions and assets of the Hansen's disease program within the Healthcare Systems Bureau since the Bureau manages a wide array of programs related to managing health care infrastructure systems and direct-targeted programs. The transferring of these functions will also allow the Bureau of Primary Health Care to focus on activities specifically related to the Health Centers program
[Provided further, That, in addition to amounts appropriated under this heading, $35,000,000 shall be available under section 241 of the PHS Act to carry out titles VII and VIII of the PHS Act:]	Citation is no longer needed because no evaluation funds are requested in Health Workforce.
For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005,[$82,534,000]: *$83,836,000, of which $127,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center:* Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by [manufacturers at the time of sale] *the Secretary based on sales data that shall be submitted by drug manufacturers* and shall be credited to this account, to remain available until expended.	Citation is added to reflect HRSA's reorganization. The Hansen's Disease Program is now part of the Health Care Systems Bureau. HRSA proposes administering and managing the functions and assets of the Hansen's disease program within the Healthcare Systems Bureau since the Bureau manages a wide array of programs related to managing health care infrastructure systems and direct-targeted programs. The transferring of these functions will also allow the Bureau of Primary Health Care to focus on activities specifically related to the Health Centers program. Language for the 340B Drug Pricing Program has been modified to reflect that HHS will collect the user fees and not the manufacturer.

Amounts Available for Obligation[3]

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Estimate
Discretionary Appropriation:			
Annual……	$6,206,204,000	$6,232,384,000	$6,015,039,000
Across-the-board reductions (L/HHS/AG, or Interior)	-$11,730,000		
Transfers from Other Accounts	$11,277,000		
American Recovery and Reinvestment Act	-		
Subtotal, adjusted appropriation……	$6,205,751,000	$6,232,384,000	$6,015,039,000
Mandatory Appropriation:			
Transfer from the Prevention and Public Health Fund	+37,000,000	-	+57,400,000
Family to Family Health Information Centers	+5,000,000	+5,000,000	-
Primary Health Care Access:			
Community Health Center Fund	+1,200,000,000	+1,500,000,000	+2,200,000,000
School-Based health Centers - Facilities	+50,000,000	+50,000,000	-
National Health Service Corps	+295,000,000	+300,000,000	+305,000,000
Subtotal Primary Health Care Access	+1,545,000,000	+1,850,000,000	+2,505,000,000
Early Childhood Visitation	+350,000,000	+400,000,000	+400,000,000
Subtotal, adjusted budget authority…….	+8,142,751,000	+8,487,384,000	+8,977,439,000
Offsetting Collections……	50,016,000	+53,016,000	+59,016,000
Unobligated balance, start of year……..	+1,061,000,000	+381,000,000	+531,000,000
Unobligated balance, end of year…….	-381,000,000	-531,000,000	-531,000,000
Recovery of prior year obligations……	+7,882,000		
Unobligated balance, lapsing…….	-3,451,000	-	-
Total obligations…….	$8,877,198,000	$8,390,400,000	$9,036,455,000

[3] Excludes the following amounts for reimbursable activities carried out by this account: FY 2012 - $40,984,000 and 20 FTE; FY 2013 - $36,984,000 and 25 FTE; FY 2014 - $36,984,000 and 25 FTE.

Summary of Changes

2012 Enacted	
Total budget authority	$6,205,751,000
(Obligations)	(-$6,184,183,000)
2014 Estimate	$6,015,039,000
(Obligations)	(-$6,015,039,000)
2012 Mandatory	$1,937,000,000
(Obligations)	(-$2,631,128,000)
2014 Mandatory	$2,962,400,000
(Obligations)	(-$2,094,400,000)
Net Change	**+$834,688,000**
(Obligations)	**-$705,872,000**

	2012 Current		Changes from Base	
		Budget Authority		**Budget Authority**
Increases:				
	FTE		FTE	
A. Built in:	1,794		-15	
1. January 2014 Civilian Pay Raise		$238,534,393		$1,523,339
2. January 2014 Military Pay Raise		$238,534,393		239,774
3. Civilian Annualization of Jan. 2013		$238,534,393		506,116
4. Military Annualization of Jan. 2013		$234,665,393		133,474
Subtotal, built-in increases				**+$2,402,702**
B. Program:				
Discretionary Increases	FTE	**FY 2012**	FTE	**FY 2014**
`		-	-	+$5,000,000
Health Care Workforce Assessment	6	2,782,000	-	+$2,218,000
Primary Care Training and Enhancement	5	38,962,000	-	+$12,000,000
Advanced Education Nursing	4	63,469,000	-	+$20,456,000

Comprehensive Care - Part B	56	1,360,827,000	-	+$10,000,000
AIDS Drug Assistance Program (Non-Add)		*933,299,000*	-	*+$10,000,000*
Early Intervention - Part C	34	215,086,000	-	+$10,000,000
Organ Transplantation	7	24,015,000	-	+$2,000,000
Program Management	862	159,894,000	-7	+$1,900,000
Family Planning	33	293,870,000	-	+$33,532,000
Subtotal Discretionary Program Increases	**1,007**	**2,158,905,000**	**-7**	**+$97,106,000**
Mandatory Increases				
Community Health Center Fund (ACA)	47	1,200,000,000	-	+$1,000,000,000
National Health Service Corps (ACA)	248	295,000,000	-	+$10,000,000
Alzheimers Prevention Fund	-	2,000,000	-	+$3,300,000
James T. Walsh Universal Newborn Hearing Screening Prev Fund	5	-	-	+$18,660,000
Heritable Disorders Prev Fund	4	-	-	+$9,834,000
Maternal, Infant and Early Childhood Visiting Program (ACA)	23	350,000,000	+2	+$50,000,000
Poison Control Centers Prev Fund	4	-	-	+$18,830,000
Subtotal Mandatory Program Increases	**331**	**1,847,000,000**	**2**	**+$1,110,624,000**
Total Program Increases	**1,338**	**$4,005,905,000**	**-5**	**+$1,207,730,000**
Decreases:				
A. Built in:				
1. Pay Costs		$238,534,393		**-$2,402,702**
B. Program:				
Discretionary Decreases				
Health Careers Opportunity Program	1	14,779,000	-1	-$14,779,000
Area Health Education Centers	2	27,230,000	-2	-$27,230,000
Public Health/Preventive Medicine	3	8,144,000	-	-$4,918,000
Nurse Education, Practice and Retention	4	39,638,000	-	-$456,000
Children's Hospitals Graduate Medical Education Program	23	265,171,000	-5	-$177,171,000
James T. Walsh Universal Newborn Hearing Screening	5	18,660,000	-	-$18,660,000
Heritable Disorders	5	9,834,000	-	-$9,834,000
Poison Control Centers	4	18,830,000	-	-$18,830,000
Rural & Community Access to Emergency Devices	2	1,100,000	-2	-$1,100,000
Rural Hospital Flexibility Grants	1	41,040,000	-	-$14,840,000
Subtotal Discretionary Program Decreases	**50**	**444,426,000**	**-10**	**-$287,818,000**

Mandatory Decreases				
School-Based Health Centers - Facilities (ACA)	5	50,000,000	-5	-$50,000,000
Mental and Behavioral Health Prevention Fund		10,000,000	-	-$10,000,000
Public Health/Preventive Medicine Prevention Fund		25,000,000	-	-$20,224,000
Family to Family Health Information Centers (ACA)	1	5,000,000	-1	-$5,000,000
Subtotal Mandatory Program Decreases	**6**	**90,000,000**	**-6**	**-$85,224,000**
Total Program Decreases	**56**	**534,426,000**	**-16**	**-$373,042,000**
Net Change Discretionary	**1,057**	**$2,603,331,000**	**-17**	**-$190,712,000**
Net Change Mandatory	**337**	**$1,937,000,000**	**-4**	**+$1,025,400,000**
Net Change Discretionary and Mandatory	**1,394**	**$4,540,331,000**	**-21**	**+$834,688,000**

Budget Authority by Activity
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 PB
1. Primary Care:			
Health Centers	1,471,999	1,491,943	1,471,999
Community Health Center Fund (ACA)	1,200,000	1,500,000	2,200,000
Health Center Tort Claims	94,893	95,474	94,893
Total, Health Centers	**2,766,892**	**3,087,417**	**3,766,892**
School-Based Health Centers - Facilities (ACA)	50,000	50,000	-
Free Clinics Medical Malpractice	40	40	40
Subtotal, Bureau of Primary Health Care	**2,816,932**	**3,137,457**	**3,766,932**
HEALTH WORKFORCE:			
2. Clinician Recruitment and Service			
National Health Service Corps (ACA)	295,000	300,000	305,000
Subtotal, National Health Service Corps	**295,000**	**300,000**	**305,000**
NURSE Corps Scholarships and Loan Repayment	83,135	83,644	83,135
Loan Repayment/Faculty Fellowships	1,243	1,264	1,243
Pediatric Loan Repayment	-	-	5,000
Subtotal, Clinician Recruitment & Service	**379,378**	**384,908**	**394,378**
3. Health Professions:			
Health Professions Training for Diversity:			
Centers of Excellence	22,909	23,049	22,909
Scholarships for Disadvantaged Students	47,452	47,742	47,452
Health Careers Opportunity Program	14,779	15,064	-
Subtotal, Health Professions Training for Diversity	**85,140**	**85,855**	**70,361**
Health Workforce Assessment	2,782	2,827	5,000
Primary Care Training and Enhancement	38,962	39,200	50,962
Oral Health Training Programs	32,392	32,919	32,392
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	27,230	30,269	-
Geriatric Programs	30,629	31,127	30,629
Alzheimer's Prevention Fund	2,000	-	5,300
Subtotal, Geriatric Programs	**32,629**	**31,127**	**35,929**

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 PB
Mental and Behavioral Health	2,892	2,939	2,892
Mental and Behavioral Health Prevention Funds	10,000		-
Subtotal, Mental and Behavioral Health	**12,892**	**2,939**	**2,892**
Subtotal, Interdisciplinary, Community-Based Linkages	**72,751**	**64,335**	**38,821**
Public Health Workforce Development:			
Public Health/Preventive Medicine	8,144	8,243	3,226
Public Health Training Centers Prevention Fund	25,000	-	4,776
Subtotal, Public Health Workforce Development	**33,144**	**8,243**	**8,002**
Nursing Workforce Development:			
Advanced Education Nursing	63,469	64,316	83.469
Nursing Workforce Diversity	15,819	16,077	15,819
Nurse Education, Practice and Retention	39,638	39,820	39,638
Nurse Faculty Loan Program	24,553	24,953	24,553
Comprehensive Geriatric Education	4,485	4,558	4,485
Subtotal, Nursing Workforce Development	**147,964**	**149,724**	**167,964**
Children's Hospitals Graduate Medical Education Program	265,171	269,488	88,000
Subtotal, Bureau of Health Professions	**678,306**	**652,591**	**461,502**
National Practitioner Data Bank (User Fees)	*28,016*	*28,016*	*28,016*
4. Maternal and Child Health:			
Maternal and Child Health Block Grant	638,646	649,046	638,646
Autism and Other Developmental Disorders	47,142	47,909	47,142
Traumatic Brain Injury	9,760	9,919	9,760
Sickle Cell Service Demonstrations	4,665	4,741	4,665
James T. Walsh Universal Newborn Hearing	18,660	18,963	-
James T. Walsh Universal Newborn Hearing/Prevention Fund	-	-	18,660
Emergency Medical Services for Children	21,116	21,460	21,116
Healthy Start	103,532	105,218	103,532
Heritable Disorders	9,834	9,994	-
Heritable Disorders/Prevention Fund	-	-	9,834
Family to Family Health Information Centers (ACA)	5,000	5,000	-

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 PB
Maternal, Infant and Early Childhood Visiting Program (ACA)	350,000	400,000	400,000
Subtotal, Maternal and Child Health Bureau	**1,208,355**	**1,272,250**	**1,253,355**
5. HIV/AIDS:			
Emergency Relief - Part A	666,071	675,366	666,071
Comprehensive Care - Part B	1,360,827	1,328,722	1,370,827
AIDS Drug Assistance Program (Non-Add)	*933,299*	*903,797*	*943,299*
Early Intervention - Part C	215,086	206,431	225,086
Children, Youth, Women & Families - Part D	77,167	77,639	77,167
AIDS Education and Training Centers - Part F	34,542	34,753	34,542
Dental Reimbursement Program Part F	13,485	13,568	13,485
Subtotal, HIV/AIDS	**2,367,178**	**2,336,479**	**2,387,178**
SPNS Evaluation Funding	*25,000*	*25,153*	*25,000*
Subtotal, HIV/AIDS Bureau	**2,392,178**	**2,361,632**	**2,412,178**
6. Healthcare Systems:			
Organ Transplantation	24,015	25,001	26,015
National Cord Blood Stem Cell Bank	11,887	11,960	11,887
C.W. Bill Young Cell Transplantation Program	23,330	23,473	23,330
Poison Control Centers	18,830	18,945	-
Poison Control Centers/Prevention Fund	-	-	18,830
340B Drug Pricing Program/Office of Pharmacy Affairs	4,472	4,499	4,472
340B Drug Pricing Program/Office of Pharmacy Affairs User Fees			*6,000*
Hansen's Disease Center	16,045	16,143	16,045
Payment to Hawaii	1,960	1,972	1,960
National Hansen's Disease Program – Buildings and Facilities	127	130	127
Subtotal, Healthcare Systems Bureau	**100,666**	**102,123**	**108,666**
7. Rural Health:			
Rural Health Policy Development	9,866	9,926	9,866
Rural Health Outreach Grants	55,553	55,893	55,553
Rural & Community Access to Emergency Devices	1,100	2,511	-
Rural Hospital Flexibility Grants	41,040	41,291	26,200

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 PB
State Offices of Rural Health	10,036	10,097	10,036
Radiation Exposure Screening and Education Program	1,935	1,947	1,935
Black Lung	7,140	7,184	7,140
Telehealth	11,502	11,572	11,502
Subtotal, Office of Rural Health Policy	**138,172**	**140,421**	**122,232**
8. Program Management	159,894	162,500	161,794
9. Family Planning	293,870	298,655	327,402
Total, Budget Authority	**6,205,751**	**6,232,384**	**6,015,039**
FTE (excludes HEAL and Vaccine)	**1859**	**1859**	**1850**

Authorizing Legislation

		FY 2013 Amount Authorized	FY 2013 Appropriations Act	FY 2014 Amount Authorized	FY 2014 President's Budget
	PRIMARY HEALTH CARE:				
1.	Health Centers: PHSA, Section 330, as amended P.L. 110-355 of the Health Care Safety Net Act of 2008, P.L. 111-148, Section 10502, PPACA	6,448,713,307	1,491,943,000	7,332,924,155	1,471,999,000
2.	Community Health Center Fund (ACA) The Affordable Care Act of 2010, Section 5601, P.L. 111-148, Section 10503, as further amended by P.L 111-152, Health Care and Education Reconciliation Act of 2010, Section 2303	1,500,000,000	1,500,000,000	2,200,000,000	2,200,000,000
3.	School Based Health Centers - Facilities Construction Affordable Care Act of 2010, Section 4101(a) of P.L. 111-148	50,000,000	50,000,000	expired	-
4.	Health Center Tort Claims: (Defense of Certain Malpractice and Negligence Suits) PHSA, Section 224, as added by P.L. 102-501 and amended by P.L. 104-73	(appropriation - $10,000,000 per year is authorized under sec. 224; funding also comes from the Health Center line)	95,474,000	(appropriation - $10,000,000 per year is authorized under sec. 224; funding also comes from the Health Center line)	94,893,000
5.	Free Clinic Medical Malpractice: Section 224, PHS Act, as added to the PHS Act by P.L. 104-191, amended by Section 10608, P.L. 111-148	(appropriation $10,000,000 per year is authorized)	40,000	appropriation - $10,000,000 per year is authorized	40,000
	CLINICIAN RECRUITMENT & SERVICE:				
6.	National Health Service Corps (NHSC) PHSA, Sections 331-338, as amended by P.L. 110-355 Health Care Safety Net Act of 2008, as further amended by P.L. 111-148, Section 5207	691,431,432	-	893,456,433	-
	National Health Service Corps – Fund (Affordable Care Act) P.L. 111-148, Section 10503(b)(2)	300,000,000	300,000,000	305,000,000	305,000,000
7.	Nursing Education Loan Repayment (Nurse Corps Loan Repayment Program) and Scholarship Program (Nurse Corps Scholarship Program) – PHSA, Section 846, as amended by Section 103, P.L. 107-205, as amended by Section 5310, P.L. 111-148	expired	83,644,000	expired	83,135,000

		FY 2013 Amount Authorized	FY 2013 Appropriations Act	FY 2014 Amount Authorized	FY 2014 President's Budget
8.	Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment) – PHS Act, Section 738 and 740(b), as amended by Section 5402, P.L. 111-148,	5,000,000	1,264,000	5,000,000	1,243,000
9.	Pediatric Loan Repayment Sections 775 of the PHS Act, as added by Section 5203, P.L. 111-148.	50,000,000	-	30,000,000	5,000,000
	HEALTH PROFESSIONS:				
10.	Centers of Excellence Section 736, PHS Act, as amended by Section 5401, P.L. 111-148	50,000,000	23,049,000	50,000,000	22,909,000
11.	Scholarships for Disadvantaged Students PHSA, Section 737 and Section 740(a), as amended by Section 5402(b), P.L. 111-148	SSAN	47,742,000	SSAN	47,452,000
12.	Health Careers Opportunity Program PHSA, Section 739 and Section 740 (c), as amended by Section 5402, P.L. 111-148	SSAN	15,064,000	SSAN	-
13.	National Center for Workforce Analysis PHSA, Section 761, 792 and 806(f), as amended by Section 5103, P.L. 111-148	SSAN	2,827,000	SSAN	5,000,000
14.	Primary Care Training and Enhancement PHSA, Section 747, as amended by Section 5301, P.L. 111-148	SSAN	39,200,000	50,962,000	
15.	Oral Health Training Programs PHSA, Section 748, as added by Section 5303, P.L. 111-148	SSAN	32,919,000	SSAN	32,392,000
	Interdisciplinary, Community-Based Linkages:				
16.	Area Health Education Centers PHSA, Section 751, as amended by Section 5403, P.L. 111-148	125,000,000	30,269,000	125,000,000	-
17.	Education and Training Related to Geriatrics PHSA, Section 753, as amended by Section 5305, P.L. 111-148	unspecified	31,127,000	expired	30,629,000

		FY 2013 Amount Authorized	FY 2013 Appropriations Act	FY 2014 Amount Authorized	FY 2014 President's Budget
18.	Mental and Behavioral Health PHSA, Section 756, as added by Section 5306, P.L. 111-148	35,000,000	2,939,000	expired	2,892,000
19.	Public Health /Preventive Medicine PHSA, Section 765-768, as amended by Section 10501, P.L. 111-148	SSAN	8,243,000	SSAN	8,002,000
	Nursing Workforce Development:				
20.	Advanced Education Nursing PHSA, Section 811, as amended by Section 5308, P.L. 111-148	SSAN	64,316,000	SSAN	83,469,000
21.	Nursing Workforce Diversity PHSA, Section 821, as amended by Sec. 5404, P.L. 111-148	SSAN	16,077,000	SSAN	15,819,000
22.	Nurse Education, Practice, Quality and Retention PHSA, Section 831, amended by Section 201 of P.L. 107-205, as amended by Section 5309, P.L. 111-148	SSAN	39,820,000	SSAN	39,638,000
23.	Nurse Faculty Loan Program PHSA, Section 846A, as amended by Section 5311, P.L. 111-148	SSAN	24,953,000	SSAN	24,553,000
24.	Comprehensive Geriatric Education PHSA, Section 865, as re-designated by Section 5310(b), and amended by Section 5312, P.L. 111-148	SSAN	4,558,000	SSAN	4,485,000
25.	Children's Hospitals Graduate Medical Education Program: PHSA, Section 340E, as amended by P.L. 108-490, as further amended by P.L. 109-307	expired	269,488,000	expired	88,000,000
26.	*National Practitioner Data Bank: (User Fees)* *Title IV, P.L. 99-660, Sec. 1921, SSA, P.L. 100-508, 1128E, SSA* *(also includes: Health Care Integrity and Protection Data Bank (HIPDB), Section 1128E of SSA*	Indefinite	28,016,000	indefinite	28,016,000
	MATERNAL & CHILD HEALTH:				
27.	Maternal and Child Health Block Grant: Social Security Act, Title V	indefinite	649,046,000	indefinite	638,646,000
28.	Autism and Other Developmental Disorders PHSA, Section 399BB, as added by Part R, P.L. 109-416, Reauthorized Section 2, P.L. 112-32	48,000,000	47,909,000	48,000,000	47,142,000

		FY 2013 Amount Authorized	FY 2013 Appropriations Act	FY 2014 Amount Authorized	FY 2014 President's Budget
29.	Traumatic Brain Injury Program: PHSA, Sections 1252 and 1253, as amended by Section 1304, P.L. 106-310, as further amended by Section6, P.L.110-206	expired	9,919,000	expired	9,760,000
30.	Sickle Cell Service Demonstration Grants: Section 712(c), P.L. 108-357 of the American Jobs Creation Act of 2004	expired	4,741,000	expired	4,665,000
31.	Universal Newborn Hearing Screening: PHSA, Section 399M, as amended by Section 702, P.L. 106-310, as amended by Section 2, P.L. 111-337	SSAN	18,963,000	SSAN	-
	Universal Newborn Hearing Screening/Prevention Fund	-	-	-	18,660,000
32.	Emergency Medical Services for Children: PHSA, Section 1910, as amended by Section 415, P.L. 105-392 Reauthorized Section 5603, P.L. 111-148	28,940,625	21,460,000	30,387,656	21,116,000
33.	Healthy Start: PHSA, Section 330H(a)-(d), as amended by Section 1501, P.L. 106-310, as amended by Section 2, P.L. 110-339	127,732,532	105,218,000	expired	103,532,000
34.	Heritable Disorders PHSA, Section 1109-1112 and 1114, as amended by Section 2601, P.L. 106-310, as amended by Section 2, P.L. 110-204, and as further amended by Section 1, P.L. 110-237	15,750,000	9,994,000	expired	-
	Heritable Disorders/Prevention Funds	-	-	-	9,834,000
35.	Family to Family Health Information Centers (Affordable Care Act, Section 501,), Social Security Act, as amended by Section 6064, P.L. 109-171, Reauthorized, Section 5507, P.L. 111-148, as amended by Section 624, P.L. 112-240	5,000,000	5,000,000	expired	-
	HIV/AIDS:[4]				
37.	Emergency Relief - Part A PHSA, Section. 2601-10, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	789,471,000	675,366,000	expired	666,071,000

[4] Please note that the Ryan White Program is authorized through September 30, 2013. However, the program will continue to operate. The 2009 reauthorization or the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87, October 30, 2009) does not include an explicit sunset clause. In the absence of a sunset clause, the program will continue to operate without a Congressional reauthorization.

38.	Comprehensive Care - Part B: PHSA, Section. 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	1,562,169,000	1,328,722,000	expired	1,370,827,000
39.	Early Intervention – Part C: PHSA, Section. 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	285,766,000	206,431,000	expired	225,086,000
40.	Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHSA, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	87,273,000	77,639,000	expired	77,167,000
41.	*AIDS Drug Assistance Program (Non-Add)* *PHSA, Section. 2611-31 and 2616, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87*	*950,000,000*	*903,797,000*	*expired*	*943,299,000*
42.	Special Projects of National Significance - Part F: PHSA, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	25,000,000	25,000,000	expired	25,000,000
43.	Education and Training Centers - Part F: PHSA, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	42,178,000	34,753,000	expired	34,542,000
44.	Dental Reimbursement Program - Part F: PHSA, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415,as amended by P.L.111-87	15,802,000	13,568,000	expired	13,485,000
	HEALTHCARE SYSTEMS				
45.	Organ Transplantation: PHSA, Sections 371 - 378, as amended by P.L. 108-216, P.L. 109-129 and P.L. 110-144, as further amended by P.L. 110-413	expired	25,001,000	expired	26,015,000
46.	National Cord Blood Inventory: PHSA, Section 379, as amended by Section 3, P.L. 109-129 as amended by P.L. 111-264	30,000,000	11,960,000	30,000,000	11,887,000
47.	C.W. Bill Young Cell Transplantation Program: PHSA, Sections 379-379B, as amended by Section 3,	30,000,000	23,473,000	30,000,000	23,330,000

	P.L. 109-129, as amended by P.L. 111-264				
48.	Poison Control Centers: PHSA, Section 1271-1274, as amended by P.L. 106-174, as amended by P.L. 110-377	28,600,000	18,945,000	28,600,000	
	Poison Control Centers/Prevention Fund	-	-	-	18,830,000
49.	340B Drug Pricing Program: PHSA, Section 340B, as amended by Section. 7101-7103, P.L. 111-148, as further amended by Section 2302, P.L. 111-152, and as amended by Section 204, P.L. 111-309	SSAN	4,499,000	SSAN	4,472,000
	340B Drug Pricing Program/User Fees	-	-	-	6,000,000
50.	National Hansen's Disease Program: PHSA, Section 320, as amended by Section 211, P.L. 105-78	not specified	16,143,000	not specified	16,045,000
51.	Payment to Hawaii: PHSA, Section 320(d), as amended by Section 211, P.L. 105-78	not specified	1,972,000	not specified	1,960,000
52.	National Hansen's Disease - Buildings and Facilities: PHSA, Section 320 and 321(a)	not specified	130,000	not specified	127,000
	RURAL HEALTH:				
53.	Rural Health Policy Development: Social Security Act, Section 711, Section 301 of the PHSA	indefinite	9,926,000	indefinite	9,866,000
54.	Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHSA, Section 330A, as amended by Section 201, P.L. 107-251, as amended by Section 4, P.L. 110-355	expired	55,893,000	expired	55,553,000
55.	Rural Access to Emergency Devices: PHSA, Section 313, Act, Section 413, P.L. 106-505 of the Public Health Improvement Act	expired	2,511,000	expired	-
56.	Rural Hospital Flexibility Grants: SSA, Section 1820(j), as amended by Section 4201(a), P.L. 105-33 and Section 405(f), P.L. 108-173, as amended by sec. 121, P.L. 110-275	expired	41,291,000	expired	26,200,000
57.	State Offices of Rural Health: PHSA, Section 338J, as amended by Section 301, P.L. 105-392	expired	10,097,000	expired	10,036,000
58.	Radiogenic Diseases: PHSA, Section 417C, as amended by Section 4, P.L. 106-245, as further amended by Section 103 and Section 104, P.L. 109-482	indefinite	1,947,000	indefinite	1,935,000

59.	Black Lung: Sec. 427(a), P.L. 91-173 of the Federal Mine Safety and Health Act 1977	indefinite	7,184,000	indefinite	7,140,000
60.	Telehealth: PHSA, Sec. 330I, as amended by P.L. 107-251, as amended by P.L. 108-163	expired	11,572,000	expired	11,502,000
61.	Family Planning: Grants: PHSA Title X	expired	298,655,000	expired	327,402,000
62.	Program Management:	indefinite	162,497,000	indefinite	161,794,000
63.	Health Education Assistance Loans Program:	SSAN	2,853,000	SSAN	-
64.	Vaccine Injury Compensation Program Trust Fund: PHSA, Title XXI, Subtitle 2, Parts A and D Section. 2110-19 and 2131-34	indefinite	6,517,000	indefinite	6,477,000
	<u>Unfunded Authorizations</u>:				
65.	Health Center Demonstration Project for Individualized Wellness Plans Sec. 330(s), PHS Act as added to PHS Act by sec. 4206 of P.L. 111-148				
66.	Health Information Technology Innovation Initiative Sec. 330(e)(1)(C), PHS Act (Grants for Operation of Health Center Networks and Plans), as amended by Section.101, P.L. 107-251, as amended by Section 2, P.L. 110-355, General Health Center funding authority made permanent by Section 5601 of P.L. 111-148				
67.	Health Information Technology Planning Grants Section 330(c)(1)(B) and Section 330(c)(1)(C), PHS Act, as amended by Section 101, P.L. 107-251				
68.	Electronic Health Record Implementation Initiative Section 330(e)(1)(C), PHS Act, as amended by Section 101, P.L. 107-251, as amended by Section 2, P.L. 110-355. General Health Center funding authority made permanent by Section 5601 of P.L. 111-148				
69.	Tax Exclusions, National Health Service Corps Scholarships (tuition, fees, ORC) Section 117 , Internal Revenue Code, as amended by Section 413 and 901, P.L. 107-16 (Authority sunset 12/31/2010), as amended by Section 101, P.L. 111-312 (authority sunset 12/31/2012), as further amended by sec. 101, P.L. 112-240 (authority sunset removed)				
70.	Tax Exclusion: National Health Service Corps Loan Repayment and State Loan Repayment Section 108, Internal Revenue Code, as amended by				

	Section 320, P.L. 108-357 (no sunset)					
71.	National Health Service Corp Loan Repayment and State Loan Repayment Section 108, Internal Revenue Code, as amended by Section 32(a), P.L. 108-357					
72.	Native Hawaiian Health Scholarships P.L. 100-579,as amended by Section 9168, P.L. 102-396, Section 338K PHS Act, Amended bySection 10221 of P.L. 111-148					
73.	Students to Service (S2S) Loan Repayment Pilot Program Section 338B, PHS Act					
74.	Health Professions Education in Health Disparities and Cultural Competency Section 741, PHS Act as amended by Section 401, P.L. 106-525, as amended by Section 5307, P.L. 111-148					
75.	Training Opportunities for Direct Care Workers Section 747A, PHS Act, as added by Section 5302, P.L. 111-148					
76.	Continuing Ed Support for Health Professionals Serving in Underserved Communities Section 752, PHS Act, as mend by Section 5403, P.L. 111-148					
77.	Geriatric Career Incentive Awards Section 753(e), PHS Act, as amended by Section 5305(a), P.L. 111-148					
78.	Geriatric Academic Career Awards Section 753(c), PHS Act, as amended by Section 5305(b), P.L. 111-148					
79.	Rural Interdisciplinary Training (Burdick) Section 754, PHS Act					
80.	Grants for Pain Care Education & Training, Section 759, PHS Act, as added by Section 4305, P.L.111-148					
81.	Advisory Council on Graduate Medical Education Section 762(k), PHS Act, as amended by Section 502, P.L. 107-251, as amended by Section 5103, P.L. 111-148					
82.	Health Professions Education in Health Disparities and Cultural Competency Section 807, PHS Act, as added by Section 401(b) of P.L. 106-525, as amended by Section 5307 of P.L. 111-148					
83.	Minority Faculty Fellowship Program					

	Section 738, PHS Act (authorized appropriation Section 740(b)), as amended by sec. 5104, Section 5402, and Section 10501, P.L.111-148					
84.	State Health Care Workforce Development Grants [Prevention Fund], 42 U.S.C 294r, as added by Section 5102, P.L. 111-148					
85.	Allied Health and Other Disciplines PHSA, Section 755					
86.	Nurse Managed Health Clinics [Prevention Fund], PHSA Section 330A-1, as added by Section 5208, P.L. 111-148					
87.	Patient Navigator Outreach & Chronic Disease Prevention Act of 2005: Section 340A, PHS Act as added by, P.L. 109-18, as amended by Section 3510, P.L. 111-148					
88.	Teaching Health Centers Development Grants, PHSA Section 749A, as added by Section 5508, P.L. 111-148					
89.	Report on Long Term Effects of Living Organ Donation, PHSA Section 371A.					
90.	Congenital Disabilities PHSA, Section 399T					

Appropriations History Table

	Budget Est. to Congress	House Allowance	Senate Allowance	Appropriation
FY 2005				
General Fund Appropriation:				
Base	6,022,833,000	6,305,333,000	6,941,280,000	6,858,624,000
Advance				
Supplementals				
Rescissions (Government-Wide)				-54,862,000
Rescissions (L/DHHS/E)				-747,000
Transfers				
Subtotal	6,022,833,000	6,305,333,000	6,941,280,000	6,803,015,000
FY 2006				
General Fund Appropriation:				
Base	5,966,144,000	6,443,437,000	7,374,952,000	6,629,661,000
Advance				
Supplementals				3,989,000
Rescissions (Government-Wide)				-66,297,000
Rescission, CMS				-4,509,000
Subtotal	5,966,144,000	6,443,437,000	7,374,952,000	6,562,844,000
FY 2007				
General Fund Appropriation:				
Base	6,308,855,000	7,095,617,000	7,012,559,000	6,390,691,000
Mandatory Authority				3,000,000
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000
FY 2008				
General Fund Appropriation:				
Base	5,795,805,000	7,061,709,000	6,863,679,000	6,978,099,000
Mandatory Authority				9,000,000
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-121,907,000
Transfers				
Subtotal	5,795,805,000	7,061,709,000	6,863,679,000	6,865,192,000

FY 2009				
General Fund Appropriation:				
Base	5,864,511,000	7,081,668,000	6,943,926,000	7,234,436,000
Mandatory Authority				5,000,000
Advance				
Supplementals (P.L. 111-5)				2,500,000,000
Rescission of Unobligated Funds				
Transfers				
Subtotal.	5,864,511,000	7,081,668,000	6,943,926,000	9,739,436,000
FY 2010				
General Fund Appropriation:				
Base	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
Advance				
Supplementals				
Rescissions				
Transfers				9,472,000
Subtotal.	7,126,700,000	7,306,817,000	7,238,799,000	7,482,994,000
FY 2011				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	6,274,790,000
Supplementals				
Transfers				
Across-the-board reductions (L/HHS/AG, or Interior)				-$12,549,000
American Recovery and Reinvestment Act				$73,600,000
Subtotal.	7,473,522,000		7,491,063,000	6,335,841,000
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			6,206,204,000
Advance				
Supplementals				
Rescissions				
Across-the-board reductions (L/HHS/AG, or Interior)				$11,730,000
Transfers				$11,277,000
Subtotal.	6,801,262,000			6,205,751,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2013				
General Fund Appropriation:				
Base	6,067,862,000			6,232,384,000
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal	6,067,862,000			6,232,384,000
FY 2014				
General Fund Appropriation:				
Base	6,015,039,000			
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal	6,015,039,000			

Appropriations Not Authorized by Law

		Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2013
1.	Nursing Education Loan Repayment (Nurse Corps Loan Repayment Program) and Scholarship Program (Nurse Corps Scholarship Program) – PHSA, Sec. 846, as amended by Sec. 103, P.L. 107-205, as amended by Sec. 5310, P.L. 111-148	2007	SSAN	31,055,000	83,644,000
2.	Traumatic Brain Injury Program: PHSA, Sections 1252 and 1253, as amended by sec. 1304, P.L. 106-310, as further amended by Sec.6, P.L.110-206	2012	SSAN	9,760,000	9,919,000
3.	Sickle Cell Service Demonstration Grants: Section 712(c), P.L. 108-357 of the American Jobs Creation Act of 2004	2009	10,000,000	10,000,000	4,741,000
4.	Organ Transplantation: PHSA, Sections 371 - 378, as amended by P.L. 108-216, P.L. 109-129 and P.L. 110-144, as further amended by P.L. 110-413	1993	SSAN	2,767,000	25,001,000
5.	Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHSA, Section 330A, as amended by sec. 201, P.L. 107-251, as amended by sec. 4, P.L. 110-355	2012	45,000,000	55,553,000	55,893,000
6.	Rural Access to Emergency Devices: PHSA, Section 313, Act, Section 413, P.L. 106-505 of the Public Health Improvement Act	2006	5,000,000	1,485,000	2,511,000
7.	Rural Hospital Flexibility Grants: SSA, Sec. 1820(j), as amended by sec. 4201(a), P.L. 105-33 and sec. 405(f), P.L. 108-173, as amended by sec. 121, P.L. 110-275	2012	SSAN	41,040,000	41,291,000

		Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2013
8.	State Offices of Rural Health: PHSA, Section 338J, as amended by sec. 301, P.L. 105-392	2002	SSAN	4,000,000	10,097,000
9.	Telehealth: PHSA, Sec. 330I, as amended by P.L. 107-251, as amended by P.L. 108-163	2006	SSAN	6,814,000	11,572,000
10.	Family Planning: Grants: PHSA Title X	1985	158,400,000	142,500,000	298,655,000
11.	Children's Hospitals Graduate Medical Education Program: PHSA, Section 340E, as amended by P.L. 108-490, as further amended by P.L. 109-307	2011	330,000,000	268,356,000	269,488,000

Primary Health Care Tab

Narrative by Activity

PRIMARY HEALTH CARE

Health Centers

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,471,999,000	$1,491,943,000	$1,471,999,000	---
ACA	$1,200,000,000	$1,500,000,000	$2,200,000,000	+$1,000,000,000
FTCA	$94,893,000	$95,474,000	$94,893,000	---
Total	$2,766,892,000	$3,087,417,000	$3,766,892,000	+$1,000,000,000
FTE	214	214	214	---

Authorizing Legislation: Section 330 of the Public Health Service Act; as amended by Public Law 110-355 of the Health Care Safety Net Act of 2008; the Native Hawaiian Health Care Act of 1988; as amended by Section 9168 of Public Law 102-396, Section 224 of the Public Health Service Act; Public Law 111-148, the Affordable Care Act of 2010, Title V, Section 5601 and Title X, Section 10503. Public Law 111-152, Health Care and Education Reconciliation Act of 2010, Section 2303.

FY 2014 Authorization $7,332,924,155

FY 2014 CHC Fund Authorization.....$2,200,000,000

Allocation Method .....Competitive grants/cooperative agreements

Program Description and Accomplishments

For more than 45 years, health centers have delivered comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become the essential primary care provider for America's most vulnerable populations. Health centers advance the preventive and primary medical/health care home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, nearly 1,200 health centers operate nearly 9,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Nearly half of all health centers serve rural populations. In 2011, these community-based and patient-directed health centers served 20.2 million patients, providing over 80 million patient visits, at an average cost of $654.00 (including Federal and non-Federal sources of funding). Patient services are supported through Federal

Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

Health centers serve a diverse patient population:

- People of all ages: Approximately 32 percent of patients in 2011 were children (age 17 and younger); about 7 percent were 65 or older.

- People without and with health insurance: Almost four in 10 patients were without health insurance in 2011. While the proportion of uninsured patients of all ages has held steady at nearly 40 percent, the number of uninsured patients increased from 4 million in 2001 to approximately 7.4 million in 2011, proportionate to the growth in Federal health center funding. The Health Center Program will continue to monitor the number of uninsured patients served on an annual basis, as it will continue to provide an understanding of the impact of Affordable Care Act implementation in the future.

- Special Populations: Some health centers also receive specific funding to focus on certain special populations including agricultural workers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In 2011 health centers served approximately 863,000 agricultural workers and their families, more than one million individuals experiencing homelessness, 188,000 residents of public housing, and approximately 8,400 Native Hawaiians.

- Migrant Health Centers: In 2011, HRSA-funded health centers served nearly 863,000 migratory and seasonal agricultural workers and their families. It is estimated these health center programs serve more than one quarter of all migratory and seasonal agricultural workers in the U.S. (National Agricultural Workers Survey – Department of Labor). The Migrant Health Center Program provides support to health centers to deliver comprehensive, high quality, culturally competent preventive and primary health services to agricultural workers and their families with a particular focus on the occupational health and safety needs of this population. Principal employment for agricultural workers must be in agriculture.

- Health Care for the Homeless Program: Homelessness continues to be a pervasive problem throughout the U.S., affecting rural as well as urban and suburban communities. According to the HUD 2010 Annual Homeless Assessment Report to Congress, it was estimated that 1.6 million people were homeless. In 2011, more than one million persons experiencing homelessness were served by HRSA-funded health centers. In particular, the Health Care for the Homeless Program is a major source of care for homeless persons in the U.S., serving patients that live on the street, in shelters, or in transitional housing. Health Care for the Homeless grantees recognize the complex needs of homeless

persons and strive to provide a coordinated, comprehensive approach to health care including substance abuse and mental health services.

- Public Housing Primary Care Health Centers: The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In 2011, HRSA-funded health centers served approximately 188,000 residents of public housing through these grants.

- Native Hawaiians: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of the Native Hawaiian Health Care Systems. Native Hawaiians face cultural, financial, social, and geographic barriers that prevent them from utilizing existing health services. In addition, health services are often unavailable in the community. The Native Hawaiian Health Care Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In 2011, Native Hawaiian Health Care Systems provided medical and enabling services to more than 8,400 people.

Allocation Method: Public and non-profit private entities, including tribal, faith-based and community-based organizations are eligible to apply for funding under the Health Center Program. New health center grants are awarded based on a competitive process that includes an assessment of need and merit. In addition, health center grantees are required to compete for their existing service areas at the completion of every project period (generally every 3 years). New health center grant opportunities are announced nationally and objective review committees (ORC), composed of experts who are qualified by training and experience in particular fields related to the Program, then review applications.

Funding decisions are made based on committee assessments, announced funding preferences and program priorities. In addition to the ORC score, various statutory awarding factors are applied in the selection of health center grants. These include funding priorities for applications serving a sparsely populated area; consideration of the rural and urban distribution of awards (no more than 60 percent and no fewer than 40 percent of projected patients come from either rural or urban areas); and a requirement for continued proportionate distribution of funds to the special populations served under the Health Center Program. Health centers demonstrate performance by increasing access, improving quality of care and health outcomes, and promoting efficiency.

Increasing Access: Health centers continue to serve an increasing number of the Nation's medically underserved. The number of health center patients served in 2011 was 20.2 million. This increased access beyond the 10.3 million patients served in 2001

represents over a 96 percent increase within a 10-year period, and an increase of approximately 3.4 million uninsured patients since 2001. Of the 20.2 million patients served and for those for whom income status is known, 93 percent were at or below 200 percent of the Federal poverty level and over 36 percent were uninsured. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

Improving Quality of Care and Health Outcomes: Health centers continue to provide quality primary and related health care services, improving the health of the Nation's underserved communities and vulnerable populations. For example, by monitoring timely entry into prenatal care, the program assesses both quality of care as well as health center outreach efforts. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes.

Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in 2000 to 70 percent in 2011, exceeding the target of 61.3 percent. It should also be noted that health centers serve a higher risk prenatal population than seen nationally, making progress on this measure a particular accomplishment.

Appropriate prenatal care management can also have a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birth weight rates is one way to measure quality of care and health outcomes for health center women of childbearing age, a key group served by the Program. This measure is benchmarked to the national rate to demonstrate how health center performance compares to the performance of the nation overall. In 2010, 7.4 percent of babies born to health center prenatal care patients were low birth weight, a rate that is 8.6 percent lower than seen nationally (8.1%).

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in 2008. In 2011, 63 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90). Additionally, 71 percent of adult health center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%).

Promoting Efficiency: Health centers provide cost effective, quality primary health care services. The Program's efficiency measure focuses on maximizing the number of health center patients served per dollar as well as keeping cost increases below annual national health care cost increases while maintaining access to high quality services. In the analysis of the annual growth in total cost per patient, the full complement of services (medical, dental, mental health, pharmacy, outreach, translation, etc.) that make health

centers a "health care home" is captured. In 2009, health center costs grew by two percent, well under the target growth rate of 5.8 percent. In 2010, health center costs grew by five percent, which was above the national rate. In 2011, the health center rate was 3.8 percent compared to a national rate of 3.9 percent. The 2010 result reflects the short-term costs associated with managing operations while implementing significant facility improvements, including major construction and renovation projects.

It is expected that as health center capital improvement projects are completed, the long-term benefits of increased capacity and improved quality of care will be realized, and cost increases will remain below national comparison data, as has been the case historically. By keeping increases in the cost per individual served at health centers better than national per capita health care cost increases, the Program has served more patients that otherwise would have required additional funding to serve annually, and demonstrates that it delivers its high quality services at a more cost-effective rate. Success in achieving cost-effectiveness may in part be related to health centers' use of a multi- and interdisciplinary team that treats the "whole patient." This, in turn, is associated with the delivery of high quality, culturally competent and comprehensive primary health care services that not only increases access and reduces health disparities, but promotes more effective care for health center patients with chronic conditions.

The Program is implementing improvements that include: 1) a Patient-Centered Medical Home (PCMH) initiative designed to improve the quality of care in health centers and support their efforts to achieve national PCMH recognition or accreditation; and 2) program-wide collection of core quality of care and health outcome performance measures, such as hypertension and diabetes-related outcomes, from all grantees.

External Evaluation: In addition to internal monitoring of health center performance, peer reviewed literature and major reports continue to document that health centers successfully increase access to care, promote quality and cost-effective care, and improve patient outcomes, especially for traditionally underserved populations.

> FQHCs and look-alikes demonstrated equal or better performance than private practice PCPs on select quality measures despite serving patients who have more chronic disease and socioeconomic complexity (Goldman LE, Chu PW, Tran H, Romano MJ, Stafford RS; 2. American Journal of Preventive Medicine 2012 Aug;43(2):142-9).
>
> Rural counties with a community health center site had 33 percent fewer uninsured emergency department (ED) visits per 10,000 uninsured populations than those rural counties without a health center site. Rural health center counties also had fewer ED visits for ambulatory care sensitive visits – those visits that could have been avoided through timely treatment in a primary care setting. (Rust George, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health, Winter 2009 25(1):8-16.)

Uninsured health center patients were more likely than similar patients nationally to report a generalist physician visit in the past year (82% vs. 68%), have a regular source of care (96% vs. 60%), receive a mammogram in the past two years (69% vs. 49%), and receive counseling on exercise (68% vs. 48%) (Shi L., Stevens G.D., and Politzer R.M. Medical Care 2007; 45(3): 206-213).

Health centers providing enabling services that were linguistically appropriate helped patients obtain health care (Weir R, et al. Use of Enabling Services by Asian American, Native Hawaiian, and Other Pacific Islander Patients at 4 Community Health Centers. Am J Public Health 2010 Nov; 100(11): 2199 – 2205).

Emergency department visits are higher in counties with limited access to primary care (Hossain MM, Laditka JN. Using hospitalization for ambulatory care sensitive conditions to measure access to primary health care: an application of spatial structural equation modeling. Int J Health Geogr. 2009 Aug 28;8:51).

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which employees of eligible health centers may be deemed to be Federal employees qualified for malpractice coverage under the FTCA. The health center, its employees, and eligible contractors are considered Federal employees immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal government assumes responsibility for such claims. Key Program activities for risk mitigation include risk management of reviews and sites visits as well as risk management technical assistance and resources to support health centers. In FY 2009, 107 claims were paid through the FTCA Program, totaling approximately $45.6 million, in FY 2010, 103 claims were paid totaling $52.6 million, in FY 2011, 103 claims were paid totaling $82.8 million, and in FY 2012, 107 claims were paid totaling $68.1 million.

Affordable Care Act

The Affordable Care Act authorized and appropriated $11 billion over five years to establish a Community Health Center Fund to provide for expanded and sustained national investment in health centers under Section 330 of the Public Health Service Act. Of this amount, $1.5 billion was appropriated to support major construction and renovation projects at community health centers nationwide and $9.5 billion to support ongoing health center operations, the establishment of new health center sites in medically underserved areas and expand preventive and primary health care services at existing health center sites. The amount appropriated to support health center services is $1 billion in FY 2011, $1.2 billion in FY 2012, $1.5 billion in FY 2013, and $2.2 billion in FY 2014.

In FY 2012, approximately $738 million in ACA funding was awarded through two funding opportunities for health centers to address capital development needs. The Health Center Capital Development-Building Capacity Program provided approximately

$629 million to 171 health centers to improve their capacity to provide primary and preventive health services to medically underserved populations. The Health Center Capital Development-Immediate Facility Improvement Program provided approximately $99 million to 227 health centers to improve immediate facility needs within existing health center sites. The Affordable Care Act funding supported 219 health center new access point grants, and continuation activities for over 1,100 health centers in FY 2012.

Enhancing HIV/AIDS Care: In FY 2012, the Health Center Program provided approximately $5 million in support of the President's National HIV/AIDS Strategy, for a joint effort with the Ryan White Part C Program to enhance care and treatment for individuals living with HIV and AIDS at health centers that are also service providers under Ryan White Part C HIV/AIDS.

HRSA has established a new goal related to the Health Center Program Patient Centered Medical Home (PCMH) Initiative. Since FY 2011, data has been collected on the percentage of health centers recognized as a patient centered medical home by a national accrediting organization. This is a HHS Priority Goal for FY 2012 through 2013. At the end of FY 2012, 13 percent of health centers were recognized as PCMHs. The FY 2014 target for this goal is for 40 percent of health centers to be recognized as PCMHs.

In FY 2013, additional Affordable Care Act funding is projected to support health center new access point grants and health center controlled networks to support health information technology and quality improvement activities in health centers as well as continuation activities for over 1,200 health centers.

The Affordable Care Act presents opportunities for the safety net to serve patients who otherwise cannot afford or gain access to care. In FY 2014, the Health Center program will continue to provide high quality, affordable and comprehensive primary care services in medically underserved communities across the country as insurance coverage expands. Health centers will also remain a vital source of primary care for insured patients seeking a quality source of care, often for services not covered by health insurance. The FY 2014 Budget request maintains the FY 2012 budget authority, sustaining current services while planning for major changes that will come at various times in FY 2014. The FY 2014 request maintains the flexibility to plan for anticipated changes during implementation of coverage provisions while providing care for the uninsured and underinsured.

Funding History

FY	Amount
FY 2010	$1,185,146,000
FY 2011	$1,580,749,000
FY 2011 ACA Funding	$1,000,000,000
FY 2012	$1,471,999,000
FY 2012 ACA Funding	$1,200,000,000
FY 2013	$1,491,943,000
FY 2013 ACA Funding	$1,500,000,000
FY 2014	$1,471,999,000
FY 2014 ACA Funding	$2,200,000,000

Budget Request

The FY 2014 Budget Request is $3,766,892,000. The FY 2014 Request is $1,000,000,000 above the FY 2012 Enacted Level, and includes $2,200,000,000 from ACA mandatory funding. This request will support the program's achievement of its ambitious performance targets and continue to enable the provision of access to primary health care services and the improvement of the quality of care in the health care safety net. This request also supports $94,893,000 for the FTCA Program, which is equal to the FY2012 Enacted Level.

Health centers will continue to be a critical element of the health system as the U.S. expands insurance coverage through the ACA, largely because they can provide an accessible and dependable source of primary care services in underserved communities. As such, the long-term strategy for the Health Center Program takes into account the need to open new health centers in areas in the country where they do not currently exist.

The FY 2014 Budget Request will support the program's achievement of its performance targets including the performance improvement efforts within health centers. Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up site visits and supports HRSA's Information Technology costs. The Program will continue to achieve its goal of providing access to care for underserved and vulnerable populations. Health centers served 20.2 million patients in 2011, and are projected to serve approximately 22.6 million patients at the FY 2014 Budget Request level.

As part of the program's efforts to improve quality of care and health outcomes, the health center program has established ambitious targets for FY 2014 and beyond. For low birth weight, the Program seeks to be at least 5 percent below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for LBW and adverse birth outcomes. The FY 2014 target for the program's hypertension measure is that 63 percent of adult

patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2014 target for the program's diabetes management measure is 71 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent). These targets will be challenging to achieve because chronic conditions require treatment with lifestyle modifications, usually as the first step, and, if needed, with medication.

The Program will also continue to promote efficiency and aims to keep cost per patient increases below annual national health care cost increases, as noted in the Center for Medicare and Medicaid Services' (CMS) National Health Expenditure Amounts and Projections. By benchmarking the health center efficiency to national per capita health care cost increases, the measure takes into account changes in the healthcare marketplace while demonstrating the Program's continued ability to deliver services at a more cost-effective rate. The target for FY 2014 is to keep the program's cost per patient increase below the 2014 national health care cost increase. To assist in areas of cost-effectiveness, the Program offers technical assistance to grantees to review costs and revenues and develop plans to implement effective cost containment strategies. By restraining increases in the cost per individual served at health centers, the Health Center Program is able to serve a volume of patients that otherwise would have required additional funding to serve, and demonstrates that it delivers its high quality services at a more cost effective rate.

The FY 2014 Budget Request will also support the program's ongoing involvement in an agency-wide effort to improve quality and program integrity in all HRSA-funded programs that deliver direct health care. One example is an increased use of on-site evaluations at health centers to verify compliance with program policies. Another key step the Health Center Program has taken in this area is to establish a core set of clinical performance measures for all health centers. The Program has aligned its required clinical performance measures with the Department's Meaningful Use measures. These measures are also consistent with the overarching goals of Healthy People 2020, and include immunizations; prenatal care; cancer screenings; cardiovascular disease/hypertension; diabetes; weight assessment and counseling for children and adolescents; adult weight screening and follow up; tobacco use assessment and counseling; and asthma treatment. In FY 2012, the Health Center Program began collecting data on three additional clinical performance measures: coronary artery disease/cholesterol; ischemic vascular disease/aspirin; and colorectal cancer screening.

In addition to tracking these core clinical indicators, health center grantees also report their health outcome measures (low birth weight, diabetes, and hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes. To support quality improvement, the Program will continue to facilitate national and State-level technical assistance and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative quality activities. The Program continues to promote the integration of Health Information Technology (HIT) into health

centers as part of HRSA's strategy to assure that key safety-net providers are not left behind as this technology advances.

Funding will also allow the Program to continue to coordinate and collaborate with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve health centers. The Program will continue to work with the CMS and the Office of the National Coordinator for Health Information Technology (ONC) on HIT, and the Centers for Disease Control and Prevention (CDC) to address Migrant Stream Farmworker issues and HIV prevention initiatives, and the National Institutes of Health (NIH) on U.S.-Mexico Border health issues, among others. In addition, the Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will also work closely with the Department of Justice on the Federal Tort Claims Act (FTCA) Program, which provides medical malpractice liability protection to section 330 supported health centers. Additionally, the proposed Budget will allow coordination with programs in the Departments of Housing and Urban Development, Education, and Justice (HUD, Ed, and DOJ).

IT Investments

The Health Centers Program funds four IT Investments. The HRSA Bureau of Primary Health Care Management Information System (BPHCMIS) investment supports the goal of Increasing Access to Quality Health Care by: collecting, storing and analyzing health center performance data; providing real-time reports on health center services and sites; and assessing and tracking health centers against key program requirements. Through the monitoring of health center performance data on access, cost and quality of care indicators, HRSA can identify successful practices, develop effective training and technical assistance resources, and work to improve the performance of health centers. By assessing health centers against the key program requirements, HRSA can assure that resources are being appropriately and effectively utilized, consistent with legislative intent and the program's strategic goals.

The program's investment in the Application Submission and Processing System (ASAPS) streamlines and expedites the application development and review process for areas, populations and facilities seeking to designate or update current Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps). The Program's investment in the Technical Assistance Support System provides HRSA with a web-based system that assists in tracking of technical assistance visits, operational site visits, and related activities/ reports to ensure effective oversight of the Health Center program. The Health Center Tort Claims Program funds the Claims Analysis Review and Tracking (CART) System IT Investment. The CART System provides an efficient mechanism for facilitating the medical reviews and processing claims for compensation under the Federal Tort Claims Act.

Sources of Revenue: ($ in millions)

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Request
Health Centers	**$2,642.0**	**$2,870.7**	**$2,943.7**
Other Sources:			
Medicaid	5,370.0	5,820.0	6,120.0
Medicare	820.0	870.0	880.0
CHIP	290.0	305.0	310.0
Other Third	1,185.0	1,310.0	1,375.0
Self Pay Collections	830.0	870.0	880.0
Other Federal Grants	310.0	320.0	325.0
State/Local/Other	2,405.0	2,530.0	2,565.0
TOTAL	**$13,852.0**	**$14,895.7**	**$15,398.7**

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
1.I.A.1: Number of patients served by health centers (Output)	FY 2011: 20.2M Target: 19.7M (Target Exceeded)	20.6M	22.6M	+ 2.0M
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2011: 88% Target: 88% (Target Met)	88%	88%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Abuse (Output)	FY 2011: 72% Target: 70% (Target Exceeded)	70%	70%	Maintain
1.E: Percentage increase in cost per patient served at health centers compared to the national rate (Efficiency)	FY 2011: 3.8% Target: 20% below national rate (National Rate = 3.9%) (Target Not Met)	20% below national rate	Below national rate	N/A
1.II.B.2: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	FY 2010: 7.4%, 8.6% below national rate Target: 5% below national rate (Target Exceeded)	5% below national rate	5% below national rate	Maintain
1.II.B.3: Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Outcome)	FY 2011: 63% Target: 60% (Target Exceeded)	60%	63%	+ 3 % points

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
1.II.B.4: Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Outcome)	FY 2011: 71% Target: 71% (Target Met)	71%	71%	Maintain
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2011: 70% Target: 61.3% (Target Exceeded)	61.3%	65%	+ 3.7 % point
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2011: 93% Target: 91% (Target Exceeded)	91%	91%	Maintain
1 II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (Output)	FY 2011: 62% Target: 63% (Target Virtually Met)	63%	63%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2012: 13% Target: 13% (Target Met)	13%	40%	+ 27 % points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	1,205	1,215	1,231
Average Award	2,000,000	2,000,000	2,000,000
Range of Awards	$250,000 - $13,300,000	$250,000 - $13,300,000	$250,000 - $13,300,000
Estimated Patients Served	21,000,000	22,200,000	22,600,000

School Based Health Centers – Facilities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$50,000,000	$50,000,000	---	-$50,000,000
FTE	5	5	5	---

Authorizing Legislation: Affordable Care Act of 2010, Title IV, Section 4101(a).

FY 2014 Authorization ..... Expired

Allocation Method ..... Competitive grants

Program Description and Accomplishments

Section 4101(a) of the Affordable Care Act authorizes and appropriates funding to support grants for the establishment of school-based health centers. Funds can be used for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures.

A School Based Health Center (SBHC) is often operated as a partnership between the school and a community health organization, such as a community health center, hospital, or local health department that serves as the sponsoring facility for the SBHC. In general, services provided by the SBHC are determined locally through a collaborative approach between the families and students, the community, the school district, and associated health providers. Typically, a SBHC provides a combination of primary care, mental health care, substance abuse counseling, case management, dental health, nutrition education, health education, and health promotion. An overall emphasis is placed on the services being age appropriate, with a particular focus on prevention and early intervention.

It is expected that the proposed projects will support the SBHC in providing more effective, efficient, and quality health care. Applicants must also demonstrate how their proposal will lead to improvements in access to health services for children at a SBHC.

In FY 2011, approximately $95 million was awarded to 278 SBHCs across the country. These SBHCs currently served more than 790,000 patients and through this funding will expand their capacity to serve an additional 440,000 people. In FY 2012, more than $14 million was awarded to 45 SBHCs across the country. This funding will enable these centers to expand their capacity and modernize their facilities allowing them to treat an estimated additional 53,000 children, above the 112,000 currently being served at these centers. In FY2013, a total of $80 million was awarded to 197 SBHCs.

Funding History

FY	Amount
FY 2010	$50,000,000
FY 2011	$50,000,000
FY 2012	$50,000,000
FY 2013	$50,000,000
FY 2014	---

Budget Request

The Affordable Care Act does not authorize an appropriation amount for FY 2014. The SBHC Facility funding authorized and appropriated in FY 2010 through FY 2013 is available until expended.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
40.I: Number of new/improved sites	FY 2012: 15 (Baseline)	N/A	165	N/A

Free Clinics Medical Malpractice

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$40,000	$40,000	$40,000	---
FTE	2	2	2	---

Authorizing Legislation: Section 224 of the Public Health Service Act.

FY 2014 Authorization ..... Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The Free Clinics Medical Malpractice Program encourages health care providers to volunteer their time at free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the capacity of the health care safety net. In many communities, free clinics assist in meeting the health care needs of the uninsured and underserved. They provide a venue for providers to volunteer their services. Most free clinics are small organizations with annual budgets of less than $250,000.

In FY 2004, Congress provided first-time funding for payments of free clinic provider's claims under the Federal Tort Claims Act (FTCA). The appropriation established the Free Clinics Medical Malpractice Judgment Fund and extended FTCA coverage to medical professional volunteers in free clinics in order to expand access to health care services for low-income individuals in medically underserved areas.

Allocation Method: Qualifying Free Clinics submit applications to the Department of Health and Human Services to have volunteer providers that they sponsor deemed. Qualifying 'free clinics' or health care facilities operated by nonprofit private entities must be licensed or certified in accordance with applicable law regarding the provision of health services. They cannot: accept reimbursements from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program including Medicare or Medicaid); or impose charges on the individuals to whom the services are provided; or impose charges according to the ability of the individual involved to pay the charge.

Increasing Access: In FY 2012, 7,375 volunteer health care providers received Federal malpractice coverage through the Program, exceeding the Program target and representing an increase of approximately 1,975 volunteer providers over FY 2011, and more than 2,500 providers over the FY 2010 level.

In FY 2010, 132 free clinics operated with FTCA deemed volunteer clinicians; in FY 2011, 168 clinics participated; and in FY 2012, 192 clinics participated, exceeding the Program's annual target. The Program also examines the quality of services annually by monitoring the percentage of free clinic health professionals meeting licensing and certification requirements. Performance continues to meet the target with 100 percent of FTCA deemed clinicians meeting appropriate licensing and credentialing requirements. In FY 2011, the Program supported 462,455 patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the vulnerable populations served by these clinics. In FY 2010, the cost per provider was $115; in FY 2011, the cost was $109 per provider; and in FY 2012 the cost was $71 per provider. In each year, the Program performance target has been exceeded.

To date there have been two claims filed. The first claim was dismissed, and the second claim is under review. There have been no paid claims under the Free Clinics Medical Malpractice Program. The Program Fund has a current balance of approximately $1 million.

Funding History

FY	Amount
FY 2009	$40,000
FY 2010	$40,000
FY 2011	$40,000
FY 2012	$40,000
FY 2013	$40,000
FY 2014	$40,000

Budget Request

The FY 2014 Budget Request is $40,000, which is equal to the FY 2012 Enacted Level. The total request will support the Program's continued achievement of its ambitious performance targets addressing its goal of increasing access and capacity in the health care safety net.

Targets for FY 2014 focus on increasing the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage to 7,600 while also increasing the number of free clinics operating with FTCA deemed volunteer clinicians to 200. The focus on quality will continue to hold the Program to a target of 100 percent for FTCA deemed clinicians meeting appropriate licensing and certification requirements. The Program will also continue to promote efficiency by restraining growth in the annual

Federal administrative costs necessary to deem each provider, with a target of $125 administrative cost per provider in FY 2014.

The FY 2014 Budget Request will also support the Program's continued coordination and collaboration with related Federal programs in order to further leverage and promote efforts to increase the capacity of the health care safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by HRSA, to share program expertise. In addition, the two programs control costs by sharing a contract to process future claims, and by providing technical support and outreach. The Program will coordinate with non-profit free clinic-related umbrella groups on issues related to program information dissemination and outreach and will continue to collaborate with the Department of Justice (DOJ) and the HHS Office of General Counsel (HHS/OGC) to assist in drafting items including deeming applications and related policies. The Program continues to work with the HHS/OGC to answer legal technical assistance issues raised by free clinics in the Program and clinics interested in joining the Program.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2012: 7,375 Target: 4,800 (Target Exceeded)	4,800	7,600	+2,800
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians (Outcome)	FY 2011: 462,455 Target: 320,000 (Target Exceeded)	320,000	476,000	+156,000
2.I.A.2: Number of free clinics operating with FTCA deemed volunteer clinicians (Output)	FY 2012: 192 Target: 155 (Target Exceeded)	155	200	+45
2.I.A.3: Percent of volunteer FTCA deemed clinicians who meet certification and privileging requirements (Output)	FY 2012: 100% Target: 100% (Target Met)	100%	100%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
2.E: Administrative costs of the program per FTCA covered volunteer (Efficiency)	FY 2012: $71 Target: $155 (Target Exceeded)	$155	$125	-$30

Health Workforce tab

HEALTH WORKFORCE

CLINICIAN RECRUITMENT AND SERVICE

National Health Service Corps

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
NHSC Field BA	---	---	---	---
NHSC Recruitment BA	---	---	---	---
NHSC Mandatory	$295,000,000	$300,000,000	$305,000,000	+$10,000,000
Total NHSC	$295,000,000	$300,000,000	$305,000,000	+$10,000,000
Total FTE	248	248	248	---
Ready Responders (non-add)	23	23	23	---

Authorizing Legislation: Public Health Service Act, Sections 331-338, as amended by Health Care Safety Net Act of 2008, P.L. 110-355, as further amended by P.L. 111-148, Section 5207 and Section 10503(b) (2)

FY 2014 Authorization $893,456,433

FY 2014 Authorization (ACA) $305,000,000

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to build healthy communities by supporting qualified health care providers dedicated to working in areas of every State, Territory, and Possession of the United States with limited access to care. In 2012, NHSC clinicians working at NHSC service sites provided primary medical, oral, and mental and behavioral health care to 10.4 million underserved people in these communities, known as Health Professional Shortage Areas (HPSAs). As of December 31, 2012, there were nearly 56.8 million people living in 5,852 primary care HPSAs, with additional HPSAs being designated for dental and mental health shortages. Based on a panel size of 3,500 individuals to 1 physician, it would take nearly 7,550 physicians to eliminate these primary care HPSAs.

By the end of FY 2013, the NHSC expects that it will have offered recruitment incentives, in the form of scholarship and loan repayment support, to over 44,400 health

professionals committed to providing care to underserved communities over its 41-year history. NHSC clinicians have expanded access to high quality health services and improved the health of underserved people.

In particular, the NHSC has partnered closely with the federally-funded Health Centers to help meet their staffing needs. Approximately 50 percent of NHSC clinicians serve in Health Centers around the Nation. The NHSC also places clinicians in other community-based systems of care that serve underserved populations, targeting HPSAs of greatest need.

The Affordable Care Act appropriated a total of $1.5 billion in new dedicated funding for the NHSC over five years starting in FY 2011 and allowed for programmatic changes to better support the recruitment and retention of primary care providers to communities in need. These changes included raising the maximum annual award for the NHSC Loan Repayment Program from $35,000 per year to $50,000. In addition, the Affordable Care Act permanently authorized the NHSC to offer half-time loan repayment contracts. Additionally, all full-time NHSC participants will be able to fulfill the service commitment through teaching - up to 50 percent of the 40-hour week in a Teaching Health Center, and up to 20 percent in other facilities.

The NHSC Scholarship Program provides financial support through scholarships, including tuition, other reasonable education expenses, and a monthly living stipend to health professions students committed to providing primary care in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are indicative of probable success in a career in primary care in underserved communities. The Scholarship Program provides a predictable supply of clinicians who will be available over the next one to eight years, depending on the length of their training programs. Upon completion of training, NHSC scholars become salaried employees of organized systems of care in underserved communities.

The NHSC Loan Repayment Program offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a Health Profession Shortage Areas (HPSA) of greatest need. In exchange for a minimum of two years of service, loan repayers receive up to $60,000 in loan repayment assistance. The loan repayment program recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve the Nation's most vulnerable populations.

The NHSC Students to Service (S2S) Loan Repayment Program provides loan repayment assistance of up to $120,000 to allopathic and osteopathic medical students in their last year of school in return for completing a primary care residency and working in rural and urban HPSAs of greatest need for three years.

The State Loan Repayment Program (SLRP) is a grant program, which offers a dollar-for-dollar match between the State and the NHSC for loan repayment contracts to clinicians who practice in a HPSA in that State. The SLRP serves as a complement to the

NHSC and provides flexibility to States to help meet their unique primary care workforce needs. In addition, the SLRP serves as a cost-efficient alternative to the NHSC, as the federal cost-per-clinician in SLRP is less given the matching requirement.

The combination of these programs allows flexibility in meeting the future needs (through scholars and S2S awardees) and the immediate needs (through loan repayers) of underserved communities. Tables 1 and 2 illustrate the students in the NHSC pipeline training to serve the underserved. Tables 3 and 4 illustrate the number and type of primary care providers serving in the NHSC.

Table 1. NHSC Pipeline by Program as of 09/30/12

Programs	**No.**
Scholarship Program	937
Students to Service Program	69
Total	**1,006**

Table 2. NHSC Pipeline by Discipline as of 09/30/12

Disciplines	**No.**
Allopathic/Osteopathic physicians	635
Dentists	154
Nurse Practitioners	49
Physician Assistants	156
Certified Nurse Midwives	12
Total	**1,006**

Table 3. NHSC Field Strength by Program as of 09/30/12

Programs	**No.**
Scholarship Program clinicians	502
Loan Repayment Program clinicians	8,634
Ready Responders	17
State Loan Repayment clinicians	755
Total	**9,908**

Table 4. NHSC Field Strength by Discipline as of 09/30/12

Disciplines	**No.**
Allopathic/Osteopathic physicians	2,569
Dentists	1,222

Table 4. NHSC Field Strength by Discipline as of 09/30/12

Disciplines	**No.**
Dental Hygienists	200
Nurse Practitioners	1,631
Physician Assistants	1,315
Nurse Midwives	162
Mental and Behavioral Health professionals	2,809
Total	**9,908**

In FY 2012:
ACA Funds:

- The NHSC Scholarship Program made 212 new awards and 10 continuation awards.
- The NHSC Loan Repayment Program made 2,342 new awards and 1,925 continuation awards.

In FY 2012, the NHSC nearly tripled its Field Strength from 3,601 in FY 2008 to 9,908. The primary care needs of over 10.4 million patients were served through the placement and retention of the NHSC clinicians.

In FY 2012, the NHSC implemented the **Students to Service (S2S) Loan Repayment Program**. Under this program, allopathic and osteopathic medical students in their last year of school are eligible to receive loan repayment assistance in return for completing a primary care residency and working in rural and urban HPSAs of greatest need. Contract awards will be up to $120,000 in return for three years of full-time or six years of half-time service, which will begin upon completion of the residency; it is anticipated that the majority of these clinicians will begin service in FY 2016. After the initial service period, physicians with additional eligible loans may apply for continuation awards in return for additional years of service.

In addition, the NHSC implemented an enhanced award structure in the Loan Repayment Program to encourage clinicians to seek placement in high-need HPSAs across the United States. Individuals who are employed in NHSC service sites with HPSA scores of 14 and higher were eligible to receive up to $60,000 for an initial two-year contract. Individuals working in HPSAs of 13 and below were eligible for loan repayment of up to $40,000 for a two-year contract. This policy has allowed the Corps to remain competitive with other loan repayment programs and help communities that have persistent workforce shortages. This new policy also provided the NHSC with the opportunity to make additional awards since the structure reduced the average initial, two-year, loan repayment award amount to $55,000. In FY 2011, all LRP participants were eligible for an initial award of up to $60,000 for a two-year, full-time contract.

Finally, the NHSC also implemented the Critical Access Hospital (CAH) pilot program in FY 2012, which allows the inpatient setting of a CAH to qualify as an NHSC site. Prior to FY 2012, only the outpatient clinic of a CAH was eligible and NHSC clinicians were generally limited to no more than eight hours in the inpatient setting. With the pilot, clinicians may now spend up to 24 hours per week in the CAH, with no fewer than 16 hours being spent in an affiliated outpatient clinic. In FY 2012, the NHSC approved 125 Critical Access Hospitals as NHSC service sites.

In FY 2013:
ACA Funds*:*

- The ACA provides $300,000,000 for the NHSC. These funds are projected to be distributed as follows:

    - Field Line - $61.0 million Expenditures from the NHSC Field Line are used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, and other support activities.
    - Scholarships - $41.8 million = 206 new awards and 17 continuations
    - Loan Repayment - $175.2 million = 2,125 new awards and 2,661 continuations
    - Students to Service Loan Repayment - $12.0 million = 100 new awards.
    - State Loan Repayment - $10.0 million = 285 Awards

By the end of FY 2013, the NHSC Field Strength is projected to be over 8,000 clinicians who will provide primary health services to nearly 8.5 million underserved individuals.

Funding History

FY	**Amount**
FY 2010	$141,420,000
FY 2011	$24,848,000
FY 2011 ACA Funding	$290,000,000
FY 2012	---
FY 2012 ACA Funding	$295,000,000
FY 2013	---
FY 2013 ACA Funding	$300,000,000
FY 2014	---
FY 2014 ACA Funding	$305,000,000

Budget Request

In FY 2014 there is no discretionary funding request. The Affordable Care Act has appropriated $305,000,000 for the NHSC in FY 2014, an increase of $10,000,000 above the FY 2012 Enacted level. This appropriation will fund 195 new scholarships, 16 scholarship continuations, 2,373 new loan repayment awards, 2,140 loan repayment continuations, 100 new Students to Service loan repayment awards, and 285 new State loan repayment awards.

The NHSC Affordable Care Act funding supports scholarship and loan repayment programs, and does not fund direct health care services or benefits. ACA implementation, including health insurance coverage expansion will begin in 2014. This will increase the number of lower income individuals seeking health care services and also increase demand for NHSC clinicians.

As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, as well as other safety net providers, the NHSC can build on its success in assuring access to residents of HPSAs, removing barriers to care and improving the quality of care to these underserved populations. The NHSC Program is working with many communities in partnership with State, local, and National organizations to help address their health care needs.

Funding in FY 2014 for the NHSC Programs will support efforts to work with Health Centers and other community-based systems of care to improve the quality of care provided and reduce the health disparities gap. As measurement of these efforts:

In FY 2014:

ACA Funds*:*

- The ACA provides $305,000,000 for the NHSC. These funds are projected to be distributed as follows:

    - Field Line - $62.0 M Expenditures from the NHSC Field Line are used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, and other support activities.
    - Scholarships - $42.6 M = 195 new awards and 16 continuations.
    - Loan Repayment - $178.4 M = 2,373 new awards and 2,140 continuations.
    - Students to Service Loan Repayment - $12.0 M = 100 new awards.
    - State Loan Repayment - $10.0 M = 285 Awards.

In FY 2014, the Affordable Care Act will allow for a significant impact on the NHSC Field Strength, projected to be over 7,600 and serving the primary care needs of 8 million patients.

The FY 2014 projections for NHSC field strength and number of individuals served by NHSC clinicians are lower than the actual numbers recorded in FY 2012 due in part to reductions in total NHSC funding in FY 2013 and FY 2014, compared to FY 2011 and FY 2012. In FY 2011, the NHSC had 3 streams of funding: ACA, ARRA, and Annual Appropriations – all totaling to approximately $390 million, resulting in 4,970 new two year awards, which expired at the end of FY 2012. The large number of two-year awards made in FY 2011, resulting in maximum NHSC field strength in FY 2011 (10,279 clinicians) and FY 2012 (9,908 clinicians). With ARRA funding ending after FY 2012, it is estimated that we will award only 1,900 new awards in FY 2013, or over 3,000 fewer (or over 60 percent decrease in) new awards than FY 2011.

Also, in FY 2012 HRSA began implementation of the NHSC Students to Service (S2S) program with the purpose of strengthening the primary care physician pipeline. The impact of this program on the NHSC field strength and individuals served will be seen once the first cohort of S2S physicians complete their residencies and enter the field in FY 2016.

Table 5. Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Result	FY 2014 President's Budget	FY 2014 Target +/- FY 2012 Result
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2012: 10.4 Million Target: 9.7 Million (Target Exceeded)	10.4 Million	8.0 Million	-2.4 Million
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2012: 9,908 Target: 9,193 (Target Exceeded)	9,908	7,607	-2,301
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. *(Outcome)*	FY 2011: 90% Target: 79% (Target Exceeded)	79%	80%	+1% point (this compares FY 2014 Target to FY 2012 Target)
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2012: 0.47% Target: ≤ 2.0% (Target Exceeded)	≤ 2.0%	≤ 2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2012: 14,000 Target: 14,000 (Target Met)	14,000	14,000	Maintain

Table 6. Loans/Scholarships Table

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
ACA Loans	$168,852,451	$175,200,000	$178,400,000
ACA State Loans	$9,843,582	$10,000,000	$10,000,000
ACA Scholarships	$42,940,396	$41,800,000	$42,600,000
ACA Students to Service Loan Repayment	$8,168,571	$12,000,000	$12,000,000

Table 7. NHSC Awards, by program and funding category, FYs 2007-2014

Fiscal Year	2007	2008	2009	2010	2011	2012	2013	2014
AWARDS:								
Scholarship	118	76	88	25	5	-	-	-
Scholarship Continuation	19	18	8	5	1	-	-	-
Loan Repayment	899	867	949	1,335	448	-	-	-
Loan Repayment Continuation	649	668	705	701	-	-	-	-
State Loan Repayment	280	280	400	285	-	-	-	-
ARRA Scholarship	-	-	70	185	-	-	-	-
ARRA Loan Repayment	-	-	829	2,214	1,053	-	-	-
ARRA State Loan Repayment	-	-	-	161	171	-	-	-
ACA Scholarships	-	-	-	-	248	212	201	195
ACA Scholarship Continuation	-	-	-	-	8	10	17	16
ACA Loan Repayment	-	-	-	-	2,612	2,342	2,051	2,373
ACA Loan Repayment Continuation	-	-	-	-	1,305	1,925	2,661	2,140
ACA State Loan Repayment	-	-	-	-	223	281	285	285
ACA Students to Service Loan Repayment	-	-	-	-	-	69	100	100

Table 8. NHSC Field Strength, by program and funding category, FYs 2007-2014

Fiscal Year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
FIELD STRENGTH:								
Scholars	633	598	582	523	495	425	394	257
Loan Repayers	2,535	2,451	2,597	3,201	2,010	754	-	-
State Loan Repayment	592	514	763	581	285	-	-	-
USPHS Commissioned Corps Ready Responders	57	37	37	30	23	17	0	0
Community Scholarship Clinicians	3	1	-	-	-	-	-	-
Base Field Strength (as of 9/30)	**3,820**	**3,601**	**3,979**	**4,335**	**2,813**	**1,196**	**394**	**257**
ARRA Loan Repayers	-		829	3,032	3,267	1,089	-	-
ARRA State Loan Repayment	-	-	-	161	278	130	-	-
ARRA Scholars	-		-	2	4	71	97	82
ARRA Field Strength	-	-	**829**	**3,195**	**3,549**	**1,290**	**97**	**82**
ACA Scholars	-					6	19	137
ACA Loan Repayment	-		-	-	3,917	6,791	7,054	6,565
ACA State Loan Repayment	-	-	-	-	-	625	504	566
ACA Field Strength	-	-	-	-	**3,917**	**7,422**	**7,577**	**7,268**
Total Field Strength	**3,820**	**3,601**	**4,808**	**7,530**	**10,279**	**9,908**	**8,068**	**7,607**
Placements:	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Grant	2,063	1,944	2,149	1,777	1,407	550	197	129
Non-Grant	1,757	1,657	1,830	2,558	1,406	646	197	128
ARRA Grant			448	1,310	1,775	593	49	41
ARRA Non-Grant			381	1,885	1,774	697	48	41
ACA Grant					1,959	3,414	3,789	3,634
ACA Non-Grant					1,958	4,008	3,788	3,634

NURSE Corps *(Formerly known as the Nursing Education Loan Repayment and Scholarship Program)*

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$83,135,000	$83,644,000	$83,135,000	---
FTE	29	29	29	---

Authorizing Legislation: Public Health Service Act, Section 846(a) as amended by Section 103, P.L. 107-205,Section 846(a), and Public Health Service Act, as amended by Section 5310, P.L. 111-148

FY 2014 Authorization ..... Expired

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

In 2002, the Nurse Reinvestment Act amended Section 846 of the Public Health Service Act, adding the Nursing Scholarship Program to complement the established Nursing Education Loan Repayment Program. This section of the Nurse Reinvestment Act (Section 103) was referred to as the "National Nurse Service Corps" in the legislation. Reflecting the statute section title and goals of the program, NURSE Corps was chosen as the umbrella term referring to both loan repayment and scholarship programs. The programs formerly known as the Nursing Education Loan Repayment Program and the Nursing Scholarship Program were renamed are now the NURSE Corps Loan Repayment Program and NURSE Corps Scholarship Program. This change in name does not reflect any changes in the program requirements or policies.

The NURSE Corps Loan Repayment Program (LRP), formerly known as the Nursing Education Loan Repayment Program, is a financial incentive program under which individual registered nurses (RNs) and advanced practice RNs (APRNs) such as nurse practitioners (NPs) enter into a contractual agreement with the Federal government to work full-time in a health care facility with a critical shortage of nurses, also known as a Critical Shortage Facility, in return for repayment of qualifying nursing educational loans. NURSE Corps LRP repays 60 percent of the principal and interest on nursing education loans of RNs and APRNs such as NPs with the greatest financial need in exchange for two years of full-time service at a health care facility with a critical shortage of nurses. Participants may be eligible to receive an additional 25 percent of the original loan balance for an additional year of full-time service in a critical shortage facility. A funding preference is given to those with the greatest financial need.

The Affordable Care Act of 2010 amended the NURSE Corps LRP to extend loan repayment to nurse faculty. FY 2010 was the first year NURSE Corps LRP made awards

to nurse faculty. These awards assist in the recruitment and retention of nurse faculty at accredited schools of nursing by decreasing economic barriers that may be associated with pursuing a career in academic nursing.

The NURSE Corps Scholarship Program (SP), formerly known as the Nursing Scholarship Program, offers scholarships to individuals attending accredited schools of nursing in exchange for a service commitment payback of at least two years in health care facilities with a critical shortage of nurses after graduation. The NURSE Corps SP award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. A first funding preference is given to qualified applicants who have zero expected family contribution and who are enrolled full-time in an undergraduate nursing program or a Master's NP program.

The NURSE Corps addresses the need for nurses in Critical Shortage Facilities. The LRP and SP programs receive assistance in application processing and scholar and clinician support through their contracts.

As measurements of that effort:

In FY 2012:

- NURSE Corps LRP made 720 new loan repayment awards and 732 continuation awards.
- NURSE Corps SP made 233 scholarship awards and 31 continuation awards.
- The average new NURSE Corps LRP award was $47,224. The average NURSE Corps LRP continuation was $20,339.
- The average new NURSE Corps SP award was $99,484. The average NURSE Corps SP continuation was $28,848.

In FY 2012, 64 percent of NURSE Corps LRP participants who initially received awards in FY 2010 came in for a continuation and committed to work at a critical shortage facility for an additional year. In addition, 51 percent of NURSE Corps SP awards were given to students obtaining their baccalaureate degree, and 42 percent of NURSE Corps SP awards were given to students obtaining their Master's NP degree.

In FY 2012, to contribute to program performance, the NURSE Corps finalized the methodology for identifying Critical Shortage Facilities (CSFs) for nurses, in order to better target program resources to areas and facilities of greatest need. CSFs are defined as a health care facility located in, designated as, or serving a primary medical care or mental health Health Professional Shortage Area. In FY 2012, 85 percent of the NURSE Corps LRP awards to RNs serving at a CSF were made to participants serving at a HPSA score of 14 or higher.

In FY 2013:

- NURSE Corps LRP expects to make 764 new loan repayment awards and 385 continuation awards.
- NURSE Corps SP expects to make 227 new scholarship awards and 23 continuation awards.

Funding History

FY	Amount
FY 2010	$93,864,000
FY 2011	$93,292,000
FY 2012	$83,135,000
FY 2013	$83,644,000
FY 2014	$83,135,000

Budget Request

The FY 2014 Budget Request is $83,135,000. The FY 2014 Request is equal to the FY 2012 Enacted level.

There is a shortage of nurses, including advanced practice registered nurses, such as NPs, at health facilities in certain areas of the United States. The demand has intensified for nurses prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings. National and State studies, including the HRSA's *Findings from the National Sample Survey of Registered Nurses - March 2008* demonstrate that the aging nursing workforce could reduce the supply of RNs in the future. Further, as the demand for primary health care services continues to grow, NPs play a critical role in offering these services, as evidenced by many States expanding the role of these providers in recent years. The NURSE Corps is a part of the National strategy to alleviate the immediate shortfall in the number of working nurses and to assure an adequate supply of nurses in the future.

To increase the number of NPs participating in the program, the NURSE Corps will actively recruit NPs through outreach efforts to colleges, universities and associations. In FYs 2014, 50 percent of the NURSE Corps LRP and SP funding will be targeted to support NPs.

Funding for the NURSE Corps will continue to address the facilities with a critical shortage of nurses across the U.S. As a measurement of that effort:

In FY 2014:

- NURSE Corps LRP expects to make 747 new loan repayment awards and 407 continuation awards.

- NURSE Corps SP expects to make 215 new scholarship awards and 23 continuation awards.

The NURSE Corps expects the cost of nursing education to continue to rise, increasing the average award, and thereby decreasing the total number of awards for the NURSE Corps within a given funding amount. This will decrease the number of RNs and APRNs the NURSE Corps can support in health care facilities with a critical shortage of nurses.

The NURSE Corps LRP and SP are authorized under Section 846 of the Public Health Service Act [42 USC 297n] to work in partnership with other HHS programs to encourage more people to consider nursing careers and motivate them to serve in facilities of critical shortage. The performance measures gauge these programs' contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of nurses working in Critical Shortage Facilities. Increasing the number of nurses at facilities with a critical shortage of nurses will be a key output.

In FY 2014, the proportion of NURSE Corps LRP participants who come in for a continuation and commit to work at a critical shortage facility for an additional year is projected to be 52 percent.

Another measure of program performance is the number of NURSE Corps SP awards that are issued to participants pursuing a baccalaureate degree. This measure was initially developed in 2010 when the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree in the first funding preference. In FY 2012, program shifted its focus to also include master's level Nurse Practitioners (NPs) in the first funding preference. As a result, the program is projecting that the proportion of NURSE Corps SP awardees obtaining their baccalaureate degree will be 40 percent in FY 2014 The program intends to modify the measure to account for master's level NPs.

Table 1. Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result/(Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
5.I.C.4: Proportion of NURSE Corps LRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcome)*	FY 2012: 64% Target: 50% (Target Exceeded)	50%	52%	+2% points

5.I.C.5: Proportion of NURSE Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment. *(Developmental)*	FY 2011: 82% (Target not in Place)	N/A	TBD[5]	N/A
5.I.C.6: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree.[6] *(Outcome)*	FY 2012: 51% Target: 75% (Target Not Met, but Improved)[7]	75%	40%[8]	-35% points
5.E.1: Default rate of NURSE Corps LRP and SP participants. *(Efficiency)*	FY 2012: LRP: 0.5% Target: 3.5% (Target Exceeded) SP: 8% Target: 17% (Target Exceeded)	LRP: 3.5% SP: 17%	LRP: 3% SP: 15%	LRP: -0.5% point SP: -2.0% points

[5] Data collection for this measure was first established in FY 2012 and surveyed those participants who completed their NURSE Corps obligation in FY 2011. Since FY 2011 is the only year of available data, program will establish the FY 2014 target after it receives data in the second year of reporting.

[6] This measure was designed to track the number of NURSE Corps SP awards that were issued to nurses with degrees higher than an associate's degree. When this measure was initially developed in 2010, the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree in the first funding preference. In FY 2012, program shifted its focus to also include master's level Nurse Practitioners (NPs) in the first funding preference. Program will be revising this measure to account for change in focus to master's level NPs.

[7] The FY 2012 result reflects only the NURSE Corps scholars obtaining a baccalaureate degree, since NP scholars would have already obtained a baccalaureate degree. The percentage of awardees who are obtaining nursing education higher than an associate degree level is 93%.

[8] The FY 2014 target is established at 40% to reflect the shift to awards for master's level nurses, and the fact that these awardees will have already obtained a baccalaureate degree.

Table 2. Loans/Scholarships Table

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Loans	$50,951,879	$50,186,400	$49,881,000
Scholarships	$25,040,377	$25,093,200	$24,940,500

Table 3. NURSE Corps Awards, by program, FYs 2007-2014

AWARDS	2007	2008	2009	2010	2011	2012	2013	2014
Scholarships								
New – RN	172	173	189	458	395	134	136	129
New – APRN						99	91	86
Continuations – RN	1	5	15	18	17	31	14	14
Continuations - APRN							9	9
Loan Repayment								
New – RN	289	199	717	842	671	272	420	411
New – APRN	34	35	121	112	85	234	191	187
New – NF				185	163	214	153	149
Continuations – RN	248	155	147	115	314	533	212	224
Continuations - APRN	36	37	24	20	71	97	96	102
Continuations – NF						102	77	81
Total	**780**	**604**	**1213**	**1750**	**1716**	**1716**	**1399**	**1392**

Table 4. NURSE Corps Field Strength, by program, FYs 2007-2014

FIELD STRENGTH[9]	2007	2008	2009	2010	2011	2012	2013	2014
Scholarship	218	292	285	252	282	475	583	458
Loan Repayment	980	749	1243	2112	2443	2592	1869	1918
Total	**1198**	**1041**	**1528**	**2364**	**2725**	**3067**	**2452**	**2376**

[9] Field Strength for FYs 2007-2010 are estimates. The NURSE Corps did not begin to capture field strength numbers until FY 2011.

Faculty Loan Repayment Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,243,000	$1,264,000	$1,243,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 738(a), Public Health Service Act (authorized appropriation Section 740(b)), as amended by Section 5402, and Section 10501(d), P.L. 111-148

FY 2014 Authorization……..……..$5,000,000

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

The Faculty Loan Repayment Program (FLRP) is a loan repayment program for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university for a minimum of two years. In return, the Federal Government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The employing institution must also make payments to the faculty member equal to the principal and interest amount made by the HHS Secretary for each year in which the recipient serves as a faculty member. The Secretary may waive the institution's matching requirements if the Secretary determines it will impose an undue financial hardship. The OIG found in 2002 that institutions participating in the faculty loan repayment program frequently receive full or partial waivers of the matching requirements, reducing the impact per Federal investment.

The Affordable Care Act included physician assistants as an eligible discipline for the FLRP program. In FY 2010, FLRP began accepting applications from physician assistants.

In FY 2012:
The FLRP program made 20 new loan repayment awards.

In FY 2013:
The FLRP program is expected to make 20 new loan repayment awards.

In FY 2014:
The FLRP program is expected to make 20 new loan repayment awards.

Funding History

FY	Amount
FY 2010	$1,266,000
FY 2011	$1,258,000
FY 2012	$1,243,000
FY 2013	$1,264,000
FY 2014	$1,243,000

Budget Request

The FY 2014 Budget Request is $1,243,000. The FY 2014 Request is equal to the FY 2012 Enacted level. The program expects to make an estimated 20 new awards under the FY 2014 Budget Request to health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university.

Table 1. Loans Table

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Loans	$1,223,686	$1,200,800	$1,180,850

Pediatric Specialty Loan Repayment Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	---	---	$5,000,000	+$5,000,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 775, as added by sec. 5401, P.L. 111-148

FY 2014 Authorization $30,000,000

Allocation Method ..... Competitive Awards to Individuals

Program Description

The Pediatric Specialty Loan Repayment Program (PSLRP) was created in the Affordable Care Act (Sec. 5203) to provide loan repayment to individuals in return for delivering pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services, in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty. Maximum loan repayment award is $35,000 per year with a minimum length of service of two years and a maximum of three years participation in the program; service may be in either a HPSA or medically-underserved area/population (MUA/P). Funding priorities are to be given to applicants who "(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting; (2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and (3) demonstrate financial need."

Funding History

FY	Amount
FY 2010	---
FY 2011	---
FY 2012	---
FY 2013	---
FY 2014	$5,000,000

Budget Request

The FY 2014 Budget Request is $5,000,000. The FY 2014 Request is $5,000,000 above the FY 2012 Enacted level.

Research has indicated that there is a significant shortage of pediatric subspecialists, resulting in children with serious illnesses being forced to travel long distances – or wait for several months – to see a pediatric specialist. In order to strengthen the pediatric workforce, the FY 2014 budget provides $5 million for the Pediatric Specialty Loan Repayment Program (PSLRP).

The PSLRP anticipates making 64 initial two-year awards in FY 2014, without projecting the distribution of awards across the eligible specialties in the first few years of implementation. The PSLRP will evaluate the interest generated in this Program from both the eligible disciplines and the underserved communities in an effort to establish guidelines for making awards in future years.

HEALTH PROFESSIONS

The Bureau of Health Professions (BHPr) programs support the training and development of health professionals (particularly primary care providers) to improve the health care of our Nation's communities and vulnerable populations. The BHPr programs award grants to health professions schools and training programs across the United States to develop, expand and enhance training and to strengthen the distribution of the health care workforce. These programs serve as a catalyst to advance changes in health professions training responsive to the evolving needs of the health care system.

In addition, the BHPr conducts a number of activities including the development and analysis of important health workforce studies and the maintenance of a database intended to facilitate a review of health professionals' credentials.

Summary of Request

	FY 2012 Enacted	**FY 2013 Annualized CR**	**FY 2014 President's Budget**	**FY 2014 +/- FY 2012**
Budget Authority	$641,306,000	$652,591,000	$451,426,000	-$189,880,000
Prevention & Public Health Fund[10]	$37,000,000	---	$10,076,000	-$26,924,000
Total Program Level	$678,306,000	$652,591,000	$461,502,000	-$216,804,000
FTE	115	117	111	-4

Authorizing Legislation: Titles III, VII, and VIII of the Public Health Service Act as amended by the Affordable Care Act, P.L. 111-148.

Allocation Method .....Competitive Grants/Contracts

[10] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

State of the Health Professions Workforce

Shortages in the health care workforce are expected to worsen with the increased needs of a growing and aging population, along with the retirement of current providers[11]. Access to health care services for rural and certain inner-city populations is a particular concern[12].

There are health workforce shortages in many States across many disciplines. The distribution of primary care providers is a particular concern. The gap between the supply and demand for mental and behavioral health professionals is a growing concern.

The U.S. health care delivery system is evolving to include new models of care, new technologies and updated efficiencies. A well trained, strategically deployed workforce will be required to deliver services in this environment. There will be a greater need for workforce planning that involves understanding and anticipating trends through data collection, analysis and dissemination, and preparation of the workforce pipeline to accommodate anticipated needs.

Attention to the primary care workforce is a key component of the Affordable Care Act. The emphasis on primary care is supported by ample research that the Nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient and more costly.[13]

In addition to focusing on enhancing our primary care workforce, it is important to recognize that, for our health care system to meet the growing demand for health care, it will need to train and use an efficient mix of provider types. The health care system must support an educational pipeline of sufficient size coupled with a delivery system that efficiently deploys health care workers with varied capabilities to work effectively in teams. Ensuring the skill set and division of labor is optimally applied requires fully engaging each health care team member in collaborative models of coordinated care.

Primary Care Clinician Supply

Most leading authorities recognize that there will be a shortage of primary care providers over the next decade. Depending on the models employed, there are varying estimates regarding the number and the appropriate ratio of the three professions that provide the vast majority of primary care visits: primary care physicians, advanced practice nurses (including nurse practitioners and certified nurse midwives) and physician assistants. The Health Resources and

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[11] U.S. Census Bureau, Population Division. (2008). Table 2. Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050 retrieved April 13, 2011 from http://www.census.gov/population/www/projections/files/nation/summary/np2008-t2.xls; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (2010). "Population Aging and the Use of Office-based Physician Services" retrieved April 13, 2011 from http://www.cdc.gov/nchs/data/databriefs/db41.htm

[12] Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas and Populations. Date Retrieved: February 14, 2013. Web Site: http://bhpr.hrsa.gov/shortage/

[13] U.S. Government Accountability Office (2008). *PRIMARY CARE PROFESSIONALS: Recent Supply Trends, Projections, and Valuation of Services*. Report #GAO-08-472T Available at: http://www.gao.gov/new.items/d08472t.pdf

Services Administration (HRSA) is working closely with States, academic institutions, professional organizations, other Federal agencies, and key stakeholders to build capacity to address current and anticipated shortages of doctors, nurses, and other providers in the health professions workforce.

HRSA's BHPr has invested in the production of new primary care providers, including physicians, nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) through programs authorized by Titles VII and VIII of the Public Health Service Act. The NPs, CNMs, and PAs may play an increasingly important role in service delivery as more of these practitioners enter the workforce. The NPs, CNMs, and PAs have demonstrated flexibility as they practice independently or partner with physicians in both primary care and specialty areas. Greater use of these providers has the potential to improve access, reduce expenditures, and change patterns of care.[14]

Within the primary care environment, direct patient care is also provided by registered nurses, pharmacists, nutritionists, social workers, and medical assistants. An adequate supply of these health professionals is also needed to meet the future demand for primary care services.

Primary Care Clinician Distribution

Primary care providers, particularly physicians, tend to practice in areas where supply is already high, leaving many areas of the country experiencing shortages of health professionals. Thus, although primary care clinician shortages are of broad concern nationwide, some communities – particularly rural and inner city communities – are more severely affected than others. As of December 27, 2012, approximately 56.9 million Americans were living in rural or inner-city locations designated as primary care health professional shortage areas.[15] Without attention shortages in certain parts of our Nation and among certain populations are likely to worsen.

Health Professions Strategic Priorities for 2014

Given the demands on the health care system described above, BHPr has identified certain strategies that can be employed to strengthen the health professions workforce and improve the delivery of health care. These strategies are designed to:

1. Increase capacity and improve the distribution of the primary care workforce through enhanced education and training opportunities;
2. Support innovations in health professions training that include team-based models of care founded on interprofessional education and clinical training experiences;
3. Reduce health disparities and promote health equity by increasing health care workforce diversity;
4. Enhance geriatric/elder care training and expertise; and,

[14] Naylor, M. (2006) Transitional Care: A Critical Dimension of the Home Healthcare Quality Agenda, Journal for Healthcare Quality, National Association for Healthcare Quality Vol. 28, No. 1, pp. 20–28, 40

[15] *Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas and Populations.* Date Retrieved: February 14, 2013. Web Site: http://bhpr.hrsa.gov/shortage/

5. Continue development of the National Center for Health Care Workforce Analysis to improve data collection to inform policy makers and other stakeholders on health workforce issues.

BHPr has undertaken a nationwide effort to increase the supply of the health care workforce and enhance training opportunities to improve access to care for a Nation with diverse and complex needs. Ensuring a diverse and adequate health care workforce equipped to implement innovative care models requires stronger educational and training opportunities. Through its programs, BHPr will encourage low income, rural, and minority students as well as Veterans to pursue health careers. BHPr will continue to re-shape its programs to strengthen alignment and accountability.

Priority #1: Increase capacity and improve distribution of the primary care workforce supply through enhanced education and training opportunities

The FY 2014 request supports a new initiative that, when sustained over five years (FYs 2014-2018), will increase the primary care workforce by 2,800 primary care providers (1,400 primary care PAs, and 1,400 advanced practice registered nurses). This initiative builds on the Administration's efforts to increase the number of primary care providers that began in FY 2010 with funds from the ACA's Prevention and Public Health Fund. The initiative will include grants to support traineeships to increase the number of advanced education nurses trained to practice as primary care nurse practitioners or nurse midwives, as well as grants to improve teaching quality at clinical sites, establish new clinical training sites, and expand the number of PA students trained.

BHPr will also partner with the Substance Abuse and Mental Health Services Administration on (SAMHSA) a one year, $35 million initiative to expand the mental and behavioral health workforce by approximately 3,425 individuals through the Mental and Behavioral Health Education and Training (MBHET) grant program. The funding will be used to address critical shortages in behavioral health professionals trained to address the needs of transition-age youth (16-25), as well as earlier issues among children and adolescents and their families. The MBHET expansion will increase the clinical service capacity of the behavioral health workforce by supporting training for masters level social workers, psychologists, marriage and family therapists, as well as behavioral health paraprofessionals. Emphasis will also be placed on developing minority providers as well as providers prepared to serve in medically underserved communities.

Many BHPr programs focus on both capacity and workforce redistribution. Key workforce programs that are helping improve capacity and distribution are:

1) Primary Care Training and Enhancement
2) Oral Health Training
3) Teaching Health Centers – Graduate Medical Education Program
4) Children's Hospital Graduate Medical Education Program
5) Nursing Workforce Development

Priority #2: Foster innovations and improve quality of care through health professions training

The steady production of new providers alone will not ensure that the Nation has access to high quality health care. The FY 2014 request includes a focus on improving the quality of care through enhanced health professions education, with a particular emphasis on public health, mental and behavioral health and interprofessional education. These efforts seek to combine knowledge and skills across disciplines, supporting team-based care that addresses the full range of health needs in order to maintain health and well-being and prevent disease, disability and premature death. As noted in the Institute of Medicine Report on *Primary Care and Public Health: Exploring Integration to Improve Population Health,*[16] cross-disciplinary education and collaboration among health care professionals are critical to timely, effective, and efficient coordinated care that improves safety and quality care outcomes.

The FY 2014 request builds on a history of supporting interprofessional education and teamwork. For example, the Nurse Education, Practice, Quality and Retention Program supports projects to develop and disseminate interprofessional and collaborative practice models. In FY 2014, the program will focus on supporting a range of health care professionals, including frontline workers, enhancing their skills and preparing them to be full participants in team-based care. The FY 2014 request will also continue support for the Interdisciplinary and Interprofessional Joint Degree program established in 2010, as well as a new National Center for Interprofessional Practice + Education, established in 2012. The Coordinating Center for Interprofessional Education and Collaborative Practice will facilitate the transformation of the fragmented healthcare delivery system into an integrated health system where coordinated, collaborative, team-based practice, informed by interprofessional practice and education becomes the new national norm.

Priority #3: Reduce health disparities by increasing health care workforce diversity

Disparities in health and health care in the United States are persistent and well documented. A report by the Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*[17] illustrates that patients of color receive a lower quality of care and are less likely to receive routine care. HRSA continues a strong focus on reducing disparities in the workforce. Increasing the diversity of the health professions workforce is one key to reducing health disparities due to socioeconomic, geographic, race, and ethnicity factors, as research demonstrates that health professionals who identify as racial/ethnic minorities are more likely to serve in areas of need. Increasing cultural competency training of all health professionals to identify and address health care disparities is another key strategy being implemented.

[16] Institute of Medicine. (2012) *Primary Care and Public Health: Exploring Integration to Improve Population Health.* Washington, D.C.: The National Academies Press.
[17] Institute of Medicine (2004). In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. Available at: http://www.iom.edu/Reports/2004/In-the-Nations-Compelling-Interest-Ensuring-Diversity-in-the-Health-Care-Workforce.aspx

HRSA's BHPr has increasingly focused on diversity across all program areas. The FY 2014 request includes an effort to increase minority nursing faculty through Nurse Faculty Loan Programs. BHPr administers two other programs specifically designed to increase the diversity of the health care workforce and increase cultural competency among health care workers. These programs include Centers of Excellence and Scholarships for Disadvantaged Students.

Priority #4: Focus on geriatric/elder care training and expertise including both professional and para-professional education

The number of people in the United States aged 65 and older is projected to grow by more than 14 million between 2010 and 2020—a 36 percent increase.[18] Those aged 65 and older have about twice as many visits to physician offices as their younger counterparts; just under half of these visits were to primary care physicians.[19] These data emphasize the growing demand for a health workforce that is sufficiently prepared to meet the specialized needs of an aging population. BHPr supports four programs whose primary goal is to improve access to quality health care for America's elderly by educating both students and current practitioners in the care of the geriatric patient.

Sustained funding for these programs is critical to updating both students and practitioners with new knowledge that is rapidly increasing regarding this population. BHPr is collaborating with the John A. Hartford Foundation to develop and implement evaluation methodologies to link education and training to provider practice improvement and improved health outcomes among geriatric and elder care grantees.

BHPr's geriatric programs emphasize interprofessional training, as care for geriatric patients must be coordinated among a wide range of providers who address various needs. These programs address both supply and education of geriatric specialists, while also increasing geriatrics competencies among the generalist workforce through education and training.

Key programs that will help BHPr increase the strength and quality of the geriatric workforce are:

1) Comprehensive Geriatric Education (for nurses)
2) Geriatric Education Centers
3) Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals
4) Geriatric Academic Career Awards

Priority #5: Continue growth of the National Center for Health Care Workforce Analysis

[18] U.S. Census Bureau, Population Division. (2008). Table 2. Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050 retrieved April 13, 2011 from http://www.census.gov/population/www/projections/files/nation/summary/np2008-t2.xls

[19] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (2010). "Population Aging and the Use of Office-based Physician Services" retrieved April 13, 2011 from http://www.cdc.gov/nchs/data/databriefs/db41.htm

(National Center) to improve data informing policy makers and other stakeholders on workforce issues

Given the central role of our health workforce in assuring access to care in a more effective health care system, the Nation needs to be able to assess and determine whether current production of health workers is likely to be sufficient to meet expected needs. HRSA's BHPr will track current and future workforce demands and the production of providers to serve as a resource to the Nation. While the National Center is assessing demands across all health professions, special attention is being given to the important role of the primary care workforce in a more effective health care system. The National Center, created by the Affordable Care Act, has developed systems to track primary care workforce supply and distribution. The National Center will also support research on factors most likely to influence the future supply, demand and distribution as well as the effectiveness of alternative strategies for more efficient and effective primary care. This data and knowledge are needed to guide policy development and inform future investments.

Activities of the National Center are focused on achieving the following objectives:

- Building National capacity for health workforce data collection by working with States, professional associations, and others to develop and promote guidelines for data collection and analysis;
- Improving data management, data analysis, modeling and projections to support analysis and decision making as well as evaluation of the effectiveness of workforce programs and policies;
- Building health workforce research capacity;
- Responding to information and data needs by translating data and findings to inform policies and programs, and;
- Informing the public on the current state and trends of the U.S. health workforce through reports and timely dissemination.

Workforce decision making is a shared Federal and State responsibility. The National Center will work closely with and share data and information to support effective State decision making.

Program Performance Measurement and Evaluation Activities

BHPr's Office of Performance Measurement (OPM) serves as the Bureau's focal point for performance measurement coordination, reporting, evaluation, and analysis. Specifically, the Office of Performance Measurement: (1) leads, guides, and coordinates performance measurement, performance reporting, and program evaluation activities of the Bureau's Divisions and Offices; (2) coordinates and guides the Bureau's efforts to use performance information to improve program planning and implementation; (3) maintains effective relationships within HRSA and with other federal and non-federal agencies engaged in program evaluation; (4) promotes quality improvement in health professions education through collaboration and partnerships with national and international institutes and centers for quality

improvement; and (5) works collaboratively with the National Center for Health Workforce Analysis.

Starting with the FY 2011 data collection cycle (July 1, 2011 through June 30, 2012), OPM implemented an enhanced performance tracking system for BHPr grantees that will allow staff and evaluators to closely monitor activities and outcomes associated with the over 40 health professions training and loan programs funded through BHPr. Data collected through the enhanced tracking system can be used to identify program-level characteristics (e.g., courses offered, number of trainees, competencies addressed), as well as monitor trends—including diversity and distribution—among students and trainees receiving direct financial support (e.g., loans, stipends, and scholarships). To date, OPM has led or assisted in the development and implementation of several evaluation activities including a 5-year retrospective evaluation of the Nurse Faculty Loan Program, as well as a retrospective-to-prospective evaluation of the Public Health Training Centers Program. During FY 2014, OPM will oversee the implementation of additional evaluation activities including a retrospective matched case-control study of the Primary Care Training Enhancement program; as well as prospective evaluations of the Centers of Excellence Program, the Advanced Nursing Education Traineeship Program, and the Scholarship for Disadvantaged Students Program. Findings from the ongoing evaluation of training and loan programs will be used to strengthen program performance and ensure grantees are provided with the necessary technical assistance to comply with the legislative goals and purposes of each program.

As directed by Section 5103 of the Patient Protection and Affordable Care Act, BHPr is in the process of developing a framework for the longitudinal evaluation of its health professions training and loan programs. At the beginning of FY 2013, OPM constituted a panel of experts with experience in the design and implementation of longitudinal evaluations of health profession training programs. The 8-member expert panel—consisting of clinicians, academicians and researchers—convened at the beginning of FY 2013 and participated in an all-day meeting with BHPr staff to review and discuss the proposed framework for the longitudinal evaluation of health professions training and loan programs. Experts were provided with opportunities to discuss general facilitators and barriers to the longitudinal evaluation of training and loan programs, as well as identify additional policy-related areas that should be considered by BHPr within the context of longitudinal evaluations. OPM is currently leading efforts to synthesize feedback and recommendations provided by the expert panel and refine BHPr's initial longitudinal evaluation framework. It is expected that the baseline year for the longitudinal evaluation of BHPr-funded programs will be FY 2014.

Program Accomplishments

During Academic Year 2011-2012, 46% of graduates and program completers directly funded by a Title VII or Title VIII program were underrepresented minorities and/or from disadvantaged backgrounds. While the target for FY 2011 was not met, individual-level data reported on graduates and program completers showed that Title VII and Title VIII programs[20] are producing

[20] Results based on data about Title VII and Title VIII-funded programs that provide direct financial support (e.g., loans, stipends or scholarships) to individuals for tuition and/or reasonable living expenses. Does not include results from Title VII and Title VIII-funded programs that support infrastructure-related activities.

graduates who are underrepresented minorities at higher rates than are currently in the workforce. For example, according to the most recent data on diversity in the physician workforce published by the American Association of Medical Colleges,[21] 5.5% of active physicians are Hispanic, 12.6% are Non-Hispanic Asian, and 6.3% are Non-Hispanic African American or Black. Individual-level data reported on graduates and completers of Title VII-funded medical residency programs showed that, in Academic Year 2011-2012, 9.3% of graduates were Hispanic, 21.3% were Non-Hispanic Asian, and 6.5% were Non-Hispanic African American or Black.

Similar findings were observed among graduates and completers of Title VIII-funded nursing programs. According to the most recent findings from the National Sample Survey of Registered Nurses,[22] 3.9% of nurses currently employed in nursing are Hispanic, 5.8% are Non-Hispanic Asian, and 5.6% are Non-Hispanic African American or Black. Individual-level data reported on graduates and completers of Title VIII-funded nursing programs showed that, in Academic Year 2011-2012, 4.4% of graduates were Hispanic, 4.6% were Non-Hispanic Asian, and 11.5% were Non-Hispanic African American or Black.

According to the 2010 census of physician assistants (PAs) conducted by the American Academy of Physician Assistants,[23] 6% of current PAs are Hispanic, 6% are Non-Hispanic Asian, and 5% are Non-Hispanic African American. Individual-level data reported on graduates and completers of Title VII-funded physician assistant training programs showed that, in Academic Year 2011-2012, 19% of graduates were Hispanic, 5.4% were Non-Hispanic Asian, and 5.4% were Non-Hispanic African American or Black.

Findings also showed that 54% of trainees directly funded by a Title VII or Title VIII program received at least a portion of their training in a medically underserved community (MUC) and/or health professions shortage area (HPSA)—exceeding the performance target set for FY 2011. Further analysis of data reported on clinical trainings offered during Academic Year 2011-2012 showed important distinctions between the professions. For example, on average, 1 out of every 2 trainees directly supported by a Title VIII nursing program or by a Title VII physician assistant training program received training in a MUC or HPSA. However, for medical residents directly supported by a Title VII residency program, nearly 3 out of every 4 trainees received training in a MUC or HPSA.

The overall percentage of graduates and completers who were directly supported by a Title VII or Title VIII program and went on to practice in a MUC or HPSA increased slightly between

[21] Diversity in the Physician Workforce: Facts and Figures 2010. Retrieved from https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf

[22] Health Resources and Services Administration (2010). *The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses*. U.S. Department of Health and Human Services: Rockville, MD.

[23] American Academy of Physician Assistants (2010). Physician Assistant Census Report: Results from the 2010 AAPA Census. Retrieved from http://www.aapa.org/uploadedFiles/content/Research/2010%20Census%20Report%20National%20_Final.pdf

FY 2010[24] and FY 2011. On average, close to 1 out of every 3 graduates and completers who received direct financial support from a Title VII or Title VIII program during Academic Year 2010-2011 have entered practice in a MUC or HPSA. The performance target for FY 2014 has been adjusted based on available results and it is expected that BHPr will not be able to meet the target of 43% set for FY 2012 and FY 2013.

Veterans Initiatives

Many veterans received training as healthcare providers during their time of service in the US military. BHPr is committed to ensuring that veterans have the opportunity to translate these skills and become civilian health professionals across the country. BHPr continues to engage in a number of efforts related to increasing the number of veterans trained as health professionals. For example, BHPr has provided funding priorities within several of its programs—including the Advanced Nursing Education Traineeship and PA Training in Primary Care programs —for applicants that can facilitate the transition of veterans into civilian health professions careers. In FY 2013, BHPr continues to explore opportunities within its funding announcements to support veteran transition to civilian health careers in the health professions. BHPr also continues to facilitate the 'Helping Veterans become Physician Assistants Workgroup' that was formed through a partnership between public and private stakeholders in veteran and PA education who are invested in creating a path for veterans to become civilian PAs, as well as improve the quality of education received by veterans.

In addition to focusing efforts on increasing veterans' opportunities to transition into civilian health professions careers, BHPr is also monitoring the rate at which training sites used by grantees identify veterans, active duty military, and military families as an underserved population. Results from performance data reported by BHPr grantees show that, at least 1 out of every 10 sites used to provide clinical or experiential training in BHPr-funded programs in FY 2011 specifically identified veterans, active duty military and/or military families as a vulnerable population served. BHPr will continue to monitor these trends and work to increase the overall number of training sites that serve vulnerable populations including veterans and their families.

[24]FY 2010 Actuals reported for this measure in the FY2013 Congressional Justification were misreported as 43%. Based on available performance data, the proportion of graduates and program completers entering practice in a MUC or HPSA for FY 2010 was 31%.

Funding History

FY	Amount
FY 2010	$723,494,000
FY 2010 (PPHF)	$265,400,000
FY 2011	$673,718,000
FY 2011 (ACA)	$230,000,000
FY 2011 (PPHF)	$20,000,000
FY 2012	$641,306,000
FY 2012 (PPHF)	$35,000,000
FY 2014	$451,426,000
FY 2014 (PPHF)	$10,076,000

Budget Request

The FY 2014 Budget Request is $461,502,000. The FY 2014 Request is $216,804,000 below the FY 2012 Enacted level. The FY 2014 request includes an initiative to train 2,800 additional primary care providers over five years (FYs 2014-2018). The FY 2014 request also sustains BHPr's priority investment goals of increasing the capacity and diversity of the primary care workforce and training innovations, including interprofessional education. The FY 2014 Request does not provide funding for the Health Careers Opportunity Program and the Area Health Education Centers Program. Performance targets for FY 2014 request have been adjusted based on the request and available trend data.

Outputs and Outcomes Table

Measure	Year and Most Recent Result[25]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
6.I.B.1: Proportion of graduates and program completers of Title VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds.	46% Target: 53% (Target Not Met)	53%	46%	-7 percentage points
6.I.C.1: Proportion of trainees in Title VII and VIII supported programs training in medically underserved communities.	54% Target: 45% (Target Exceeded)	45%	50%	+5 percentage points

[25] Most recent result is for Academic Year 2011-2012 and funded in FY 2011, excluding measure 6.I.C.2.

Measure	Year and Most Recent Result[25]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
6. I.C.2: Percentage of health professionals supported by Bureau of Health Professions program who enter practice in underserved areas.[26]	33% Target: 43% (Target Not Met)	43%	33%	-10 percentage points
6.I.1: Percentage of health professions trainees exposed to an interprofessional experience in an educational or practice environment supported by Bureau of Health Professions. (Developmental)	New Measure	--	TBD	--

[26] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one-year post program graduation. Results are from academic year 2010-2011. FY 2010 Actuals reported for this measure in the FY2013 Congressional Justification were misreported as 43%. Based on available performance data, the proportion of graduates and program completers entering practice in a MUC or HPSA for FY 2010 was 31%.

Proposed Allocation from the Prevention and Public Health Funding (PPHF)

Activities to Completed and Objectives Attained

The FY 2012 Prevention and Public Health Fund (PPHF) supported the following programs:

- *Public Health Training Centers (PHTC) Program* which focuses on preparing the current and future public health workforce with the goals of strengthening the public health infrastructure throughout the United States and its territories, expanding the capacity of the PHTCs to provide continuing education for the current and future public health workforce, and providing support for field placements for students in local, state and tribal public health agencies.

- *Mental and Behavioral Health Education and Training (MBHET),* which provides grants to increase the supply of mental and behavioral health professionals who pursue clinical work with high need and high demand populations

- *Alzheimer's Disease Prevention, Education and Outreach* program (*Alzheimer's prevention)* which funds Geriatric Education Centers (GEC) grantees to provide training to healthcare providers on Alzheimer's disease and related dementias.

- *Public Health Traineeship Program (PHT)* which provides grants to institutions accredited for the provision of graduate or specialized training in public health. The schools award the funds as traineeships to graduate public health students with the goal of increasing the number of professionals trained in public health shortage fields.

In FY 2014, HRSA will support:

- *Alzheimer's Disease Prevention, Education and Outreach* program (*Alzheimer's prevention)*

- *Public Health Training Centers* program

- *Preventive Medicine Residencies (PMR)* program, which supports post-graduate physician training by funding the planning, development, operation, or participation in approved residency programs in preventive medicine and public health. Preventive medicine physicians are uniquely trained in both clinical medicine and public health in order to promote, and maintain health and well-being and reduce the risks of disease, disability, and death in individuals and populations.

Level of Funding Allocated from the PPHF for Each Activity in FY 2012 and Proposed in FY 2014

In FY 2012, 37 PHTC grantees were supported with $23.9 million from the PPHF. Forty-six PHT grantees were supported: 16 were supported with $1.1 million from the PPHF; 30 were supported with funding from the regular appropriation. Approximately 20 MBHET grantees

were supported with $10 million from the PPHF. Two million dollars in PPHF resources supported Alzheimer's prevention grant supplements to 45 GECs.

In FY 2014, forty-five Alzheimer's prevention grantees are proposed to be supported with $5.3 million from the PPHF. In addition, 6 new PMR grants will be supported with $2.2 million, and 16 PHTCs will be supported with $2.6 million.

Response to the Purpose of the ACA and the PPHF

These activities respond to the purpose of the ACA and the PPHF by providing a sustained investment in prevention and public health programs. In FY 2014, BHPr will continue to collaborate with partners to assess health workforce development needs and implement health professions training and education specifically designed to meet public health and preventive medicine workforce development needs.

Funding Mechanism

Alzheimer's prevention awards will be funded as supplemental grants to the Geriatric Education Center grantees. PHTC and PMR awards will be funded as grants to eligible entities.

Method of Selection

Selection will be made through a limited competition for the Alzheimer supplements. The PHTC and PMR awards will be made as non-competing continuation awards to existing grantees.

Intended Award Recipients

- Alzheimer's Supplements – Awards will be made to existing Geriatric Education Centers.
- PHTC – Awards will be made as non-competing continuation awards to existing PHTC grantees.
- PMR – Awards will be made as non-competing continuation awards to existing PMR grantees, which include accredited schools of public health or medicine, accredited public or private non-profit hospitals, state, local or tribal health departments, or a consortium of two or more of these entities.

Health Professions Training for Diversity

Centers of Excellence

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$22,909,000	$23,049,000	$22,909,000	---
FTE	2	2	2	---

Authorizing Legislation: Section 736 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization $50,000,000

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Centers of Excellence (COE) Program seeks to increase the supply and quality of underrepresented minorities (URM) in the health professions workforce by providing grants to health professions schools and other public and nonprofit health or educational entities that meet the eligibility requirements described below. Funds support programs of excellence that enhance the academic performance of URM students, support URM faculty development, and facilitate research on minority health issues.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[27]

Eligible Entities: Health professions schools and other public and nonprofit health or educational entities that operate programs of excellence for URM individuals and meet the required general conditions regarding: (a) COEs at four designated Historically Black Colleges and Universities, (b) Hispanic COEs, (c) Native American COEs, and d) Other COEs.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allopathic medicine • Dentistry • Graduate programs in behavioral or mental	• Undergraduate • Graduate • Faculty development	• Increase outreach to URM students to enlarge the competitive applicant pool. • Establish an education

[27] U.S. Department of Health and Human Services, 2006; In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
health • Osteopathic medicine • Pharmacy		pipeline for URM students interested in health professions careers. • Develop academic enhancement programs for URM students. • Train, recruit, and retain URM faculty. • Improve information resources, clinical education, cultural competency, and curricula as they relate to minority health issues. • Facilitate opportunities for faculty and student research on minority health issues. • Train students at community-based health facilities serving minority individuals. • Provide stipends and fellowships to URM students and faculty.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of the COE program trained 3,084 underrepresented minority students and 131 faculty members. Demographic data showed that, among students trained, 38% were Hispanic, 53% were Non-Hispanic African American or Black, and 4% were Non-Hispanic Asian. Similarly, data showed that, among faculty participating in the COE program, 50% were Hispanic, 41% were Non-Hispanic African American or Black, and 2% were Non-Hispanic Asian.

Grantees of the COE program offered clinical trainings to students and faculty in over 300 sites that were primarily located in medically underserved communities and/or Health Professional Shortage Area (HPSA) and served a number of specialized populations including children and adolescent, expecting mothers, and older adults. Grantees of the COE program also offered 116 structured training programs to students and faculty; of these, results showed that the majority (47%) were 180 hours or more of instruction, suggesting a move towards offering longer and more intensive academic and clinical training experiences to students and faculty.

With regard to the COE program's performance measures, 390 URM students and 337 URM faculty participated in research activities specific to minority health issues. While the target for students participating in research specific to minority health issues was not met, the program was

able to exceed its target for the number of faculty participating in these activities by 4%. Many factors such as eligibility, enrollment trends, and/or interest in research activities specific to minority health issues may have affected school's ability to recruit URM students to participate in these specific research-related activities. Future performance measurement activities will assess faculty-student collaboration models (e.g., 1:1 models, small-class size models) used by COE grantees to determine the average faculty-to-student ratios. Using this information, out-year performance targets will be adjusted to reflect collaboration models commonly used by COE grantees.

Funding History

FY	Amount
FY 2010	$24,550,000
FY 2011	$24,452,000
FY 2012	$22,909,000
FY 2013	$23,049,000
FY 2014	$22,909,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and supports HRSA's Information Technology costs.

Budget Request

The FY 2014 Budget Request is $22,909,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. This request will continue to fund an estimated 19 continuation grants to provide support to qualifying health professions schools to facilitate faculty and student research on health issues particularly affecting URM groups, strengthen programs to enhance the academic performance of URM students attending the school, and promote faculty development in various areas, including diversity and cultural competency. The decrease in the target number of URM students participating in research on minority health issues may be related to the factors associated with the school's resources to recruit URM students to participate in the research activities, including the institution's faculty mentorship protocol, if applicable.

Starting in FY 2014, BHPr plans to evaluate the effectiveness of the COE program. This will include a comparison of the BHPr-funded activities with similar activities at institutions that do not receive BHPr funding. The evaluation will assess enrollment, retention, and graduation of URM individuals and seek to identify best practices in diversifying the health professions workforce.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /[28]Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY2012
Number of URM students participating in research on minority health issues	390 Target: 536 (Target Not Met)	536	390	-146
Number of URM faculty participating in research on minority health issues	337 Target: 323 (Target Exceeded)	323	323	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	19	19	19
Average Award	$1,205,736	$1,205,736	$1,205,736
Range of Awards	$700,000 - $4,913,500	$700,000 - $4,913,500	$700,000 - $4,913,500

[28] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$47,452,000	$47,742,000	$47,452,000	---
FTE	4	4	4	---

Authorizing Legislation: Section 737 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization ..... Unspecified

Allocation Method .....Competitive Grant

Program Goal and Description: The Scholarships for Disadvantaged Students (SDS) program increases diversity in the health professions and nursing workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds with financial need, many of whom are underrepresented minorities (URMs). The SDS program aims to increase: 1) the number of graduates practicing in primary care, 2) enrollment and retention of URMs, and 3) the number of graduates working in medically underserved communities.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[29]

Eligible Entities: Eligible entities are accredited schools of medicine, osteopathic medicine, dentistry, nursing, pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, allied health, and schools offering a graduate program in behavioral and mental health practice.

[29] U.S. Department of Health and Human Services, 2006; In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allied health • Behavioral and mental health • Chiropractic • Dentistry • Allopathic medicine • Nursing • Optometry • Osteopathic medicine • Pharmacy • Physician assistants • Podiatric medicine • Public health • Veterinary medicine	• Undergraduate • Graduate	• Provide scholarships to eligible full-time students. • Recruit and retain students from disadvantaged backgrounds including students who are members of racial and ethnic minority groups.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of the SDS program supported a total of over 22,000 disadvantaged students—exceeding the program's performance target of 18,000 by 22%. Analysis of performance data showed that, among students supported, over 13,000 were underrepresented minorities—exceeding the program's performance target of 11,200 by 16%. Results from these analyses also showed that, of the total number of students supported, 6,145 completed their program. The most recently reported SDS data indicate that one out of every three SDS graduates was reported to have entered service in a medically underserved community. [30]

Funding History

FY	Amount
FY 2010	$49,236,000
FY 2011	$49,042,000
FY 2012	$47,452,000
FY 2013	$47,742,000
FY 2014	$47,452,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, program oversight activities, and Information Technology costs.

[30] Most recent MUC data include academic year (AY) 2008 for allopathic and osteopathic graduates and AY 2010-11 for non-allopathic and non-osteopathic health professions.

Budget Request

The FY 2014 Budget Request is $47,452,000. The FY 2014 Request is the same as the FY 2012 Enacted level. This request will fund 99 grant awards, supporting approximately 2,910 students. In FY 2012, the SDS program was revised to: 1) become a competitive grant program, rather than a formulaic grant program; 2) strengthen its focus on primary care service; 3) increase required proportion of disadvantaged students for applicant eligibility; and 4) support more substantial student scholarship awards to facilitate faster degree completion and workforce entry. The FY 2014 targets have been revised to reflect these changes and it is not expected that the program will meet performance targets for FY 2012 and FY 2013, which were based on the original formulaic grant program. BHPr is planning an evaluation starting in FY 2014 to report on program accomplishments and determine if the goals of the program are being met under the revised program design. The FY 2014 Budget Request will continue to support these programs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[31]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of disadvantaged students	22,407 Target: 18,000 (Target Exceeded)	3,620	2,910	-710
Number of URM students	13,295 Target: 11,200 (Target Exceeded)	2,350	1,800	-550
Percent of students who are URMs	59% Target: 62% (Target Not Met)	65%	62%	-3%

[31] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$14,779,000	$15,064,000	---	-$14,779,000
FTE	1	1	---	-1

Authorizing Legislation: Sections 739 and 740 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization .....Such Sums as Necessary

Funding Allocation .....Competitive Grant

Program Goal and Description: The Health Careers Opportunity Program (HCOP) seeks to increase the diversity of the health professions workforce by providing grants that improve the recruitment and enhance the academic preparation of students from economically and educationally disadvantaged backgrounds into the health professions. Grant projects support activities targeted to Kindergarten through 12th grade, baccalaureate, post-baccalaureate, and/or graduate students. Activities include formal academic and research training and programming, student enhancement services, counseling and mentoring services to assist students in successfully completing their education and training, student stipends, and financial planning resources. HCOP also exposes students to community-based primary healthcare experiences with public and private non-profit providers.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[32]

Eligible Entities: Accredited health professions schools and other public or private nonprofit health or educational institutions.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
Allied health Allopathic medicine Behavioral and mental health	• Elementary school • Middle school • High school	• Identify, recruit, and select individuals from disadvantaged backgrounds for academic

[32] U.S. Department of Health and Human Services, 2006; In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
Chiropractic Dentistry Optometry Osteopathic medicine Pharmacy Physician assistants Podiatric medicine Public health Veterinary medicine	• Undergraduate • Graduate	enhancement. • Facilitate entrance to health professions schools. • Disseminate information on financial aid. • Provide stipend support. • Provide exposure at community-based primary health service facilities. • Provide counseling, mentoring, or other services to assist individuals to successfully complete their education. • Develop larger competitive applicant pool through partnerships with institutes of higher education, school districts, and other community-based linkages. • Provide preliminary education and health research training to assist students to successfully complete regular courses of education at such a school, or refer individuals to institutions providing such preliminary education.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of HCOP exceeded all of the program's performance targets. During this time, grantees trained a total of 5,333 disadvantaged students in structured programs—exceeding the program's performance target of 4,435 by 20%. Results from the analysis of performance data showed that, of the total number of students trained, over 3,100 were in grades K-12 and over 2,100 were in post-secondary education—exceeding the program's performance targets by 50% and 55%, respectively. Demographic data provided by grantees showed that, among students trained in FY 2011, 28.5% were Hispanic, 45% were Non-Hispanic African American or Black, and 12% were Non-Hispanic Asian.

Funding History

FY	Amount
FY 2010	$22,086,000
FY 2011	$21,998,000
FY 2012	$14,779,000
FY 2013	$15,064,000
FY 2014	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

No funding is requested in FY 2014. The President's Budget is prioritizing investing in programs that have a more immediate impact on the production of health professionals by supporting students who have committed to and are in training as health care professionals. Federally funded health workforce development programs will continue to promote training of individuals from disadvantaged backgrounds. For example, efforts to strengthen the diversity of the health professions workforce include the Primary Care Training and Enhancement program, which requires applicants to include a description of their recruitment and retention strategies to increase the representation of underrepresented minority and/or disadvantaged trainees in their grant applications. In addition, the Department of Education provides support to students from disadvantaged backgrounds though activities aimed at enhancing their academic preparedness in science, technology, engineering and mathematics, including through the Academic Competitiveness Grant Program and the National Science and Mathematics Access to Retain Talent Grant Program. Furthermore, many health professions training institutions have initiatives aimed at recruiting students from disadvantaged backgrounds.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[33] / Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Total number of disadvantaged students in structured programs	5,333 Target: 4,435 (Target Exceeded)	4,435	---	-4,435
Number of post-secondary disadvantaged students in structured programs	2,179 Target: 1,409 (Target Exceeded)	1,409	---	-1,409
Number of secondary	3,153 Target: 2,097	2,097	---	-2,097

[33] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Measure	Year and Most Recent Result[33] / Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
education (K-12) students in structured programs	(Target Exceeded)			

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	20	20	---
Average Award	$700,000	$681,865	---
Range of Awards	$237,000-$1,078,000	$238,000 - $750,000	---

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$2,782,000	$2,827,000	$5,000,000	+$2,218,000
FTE	6	6	6	---

Authorizing Legislation: Sections 761, 792, and 806(f) of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization .....(see below)
National Center for Health Care Workforce Analysis.....$7,500,000
State and Regional Centers $4,500,000
Increase in Grants for Longitudinal Evaluations .....Such Sums as Necessary

Allocation Method…….…….Grants/Contract

Program Description: The National Center for Health Workforce Analysis (National Center) collects and analyzes health workforce data and information in order to provide National and State policy makers and the private sector with information on health workforce supply and demand. The National Center also evaluates workforce policies regarding their effectiveness in addressing workforce issues. Activities of the National Center are focused on achieving the following objectives:

- Building National capacity for health workforce data collection by working with States, professional associations, and others to develop and promote guidelines for data collection and analysis;
- Improving data management, data analysis, modeling and projections to support analysis and decision making as well as evaluation of the effectiveness of workforce programs and policies;
- Building health workforce research capacity;
- Responding to information and data needs by translating data and findings to inform policies and programs, and;
- Informing the public on the current state and trends of the U.S. health workforce through reports and timely dissemination.

Need: Producing a workforce of sufficient size and skills is essential to meeting the Nation's health care needs. This requires better data and information than is currently available. The Nation spends billions of dollars each year on the education and training of the health workforce, yet basic data on workforce supply and demand do not exist. Effective decision making at the

Federal, State and local level requires far better data and information on the current workforce and estimates of future demands.

Program Accomplishments: The National Center continues to expand its data collection, analysis and information dissemination activities. Working with public and private partners, the National Center supports development and implementation of a national Minimum Data Set for Health Professions across a range of health professions, including physicians, nurses, physician assistants, pharmacists, dentists, physical therapists, and mental and behavioral health providers. The National Center regularly collaborates with States to provide technical assistance, information, and expertise on workforce data collection and analysis.

Continuing its work to expand the range of data available through the Area Resource File, the National Center is adding state-level data and improving the availability of on-line tools for accessing the data.

The National Center has initiated Health Workforce Research Centers to address health workforce issues of national importance and provide technical assistance to states working on data collection and health workforce planning.

The National Center will model supply and demand of health professionals across a range of health occupations.

The National Center makes health workforce information available through reports and on-line databases. Several publications are in development, with publication planned for FY 2013 and FY 2014. These include a report and chartbook on the U.S. Health Workforce 2012, a State-level health workforce data base, a report on the primary care workforce, a report on trends in the supply and education of the nursing workforce, a report on diversity in the health professions, and briefs highlighting specific health workforce topics. The National Center will also be completing a national survey on nurse practitioners.

Funding History

FY	Amount
FY 2010	$2,826,000
FY 2011	$2,815,000
FY 2012	$2,782,000
FY 2013	$2,827,000
FY 2014	$5,000,000

Budget Request

The FY 2014 Budget Request is $5,000,000. The FY 2014 Request is $2,218,000 above the FY 2012 Enacted level. This request will continue and expand FY 2013 activities, including improved and expanded data and analysis capabilities through continued implementation of the National Minimum Data Set for Health Professions, updated data on the primary care workforce to improve measurement, tracking, and assessment of the supply of health professionals,

continued expansion of the Area Resource File, improved projections for the supply and demand of health professionals now and in the future, and analysis of particular health workforce issues through the work of Health Workforce Research Centers.

The National Center will also continue coordinating and collaborating with State partners to build the foundation for more effective and useful health workforce analysis. Funding will allow the National Center to continue to work closely with States by providing them with the necessary data and technical assistance to build their workforce data and analytical capacity.

Health Care Workforce Assessment funding supports one IT Investment (BHPr Health Workforce Data Analysis and Reporting) in addition to supporting the National Center. This investment in IT supports the strategic and performance outcomes of the National Center and contributes to its success by collecting and analyzing health workforce data in order to monitor, forecast and meet long-term health workforce needs and strengthen the health workforce.

Regional Research Centers Grants Awards Table
Size of Awards

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	---	3	3
Average Award	---	$400,000	$400,000
Range of Awards	---	$300,000 - $600,000	$300,000-$600,000

Primary Care Training and Enhancement Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$38,962,000	$39,200,000	$50,962,000	+$12,000,000
FTE	5	5	5	---

Authorizing Legislation: Section 747 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The purpose of the Primary Care Training and Enhancement (PCTE) program is to strengthen medical education for physicians and physician assistants to improve the quantity, quality, distribution, and diversity of the primary care workforce. PCTE grants help produce future primary care providers that are prepared to meet the changing healthcare needs of the nation by supporting the development of innovative medical education for physicians and physician assistants.

The six funding opportunities that comprise PCTE support a range of activities, including:

- predoctoral training;
- residency training;
- physician faculty development;
- support for academic administrative units;
- physician assistant education; and
- interprofessional joint graduate degree programs.

These activities vary in eligible applicants, trainees, and approved activities, allowing for grant activities to specifically address local community and trainee needs.

Need: National and international research demonstrate that high quality, accessible primary care improves health and reduces costs, with improved satisfaction for both recipients and providers of healthcare services. There are currently too few primary care providers to meet demand and improve the nation's health. The system will be further stressed as the U.S. population grows and ages.

Difficulty recruiting students to become primary care physicians is a principle obstacle to improving the primary care system. Only 14.5 percent of all 2012 National Residency Match

Program applicants filled primary care positions (11.6 percent of U.S. senior medical students).[34] The Council on Graduate Medical Education (COGME) asserted in its 20th Annual Report "Advancing Primary Care" that the U.S. physician workforce should consist of "at least 63,000 (40 percent of total) primary care physicians" to achieve access to high quality health care and a healthy nation.[35]

Geographic mal-distribution also contributes to the shortage of primary care providers in many communities, both rural and urban. Even as the number of physicians increases, they tend to practice in areas where the supply is already high, as opposed to rural and inner city areas where need has been demonstrated and is reflected by suboptimal health outcomes.[36]

The physician and physician assistant workforce must be prepared for the expected increase in demand for health care and to help develop the delivery system and practice models that will yield higher quality and improve efficiency. Physician assistants are valuable primary care team members that are helping increase the capacity and quality of the health care system. The trends disfavoring primary care practice and working in underserved communities seen in physicians have been mirrored in physician assistants. Investments in the primary care workforce are needed to increase the number of practicing physicians and physician assistants and to enhance their educational experience.

Eligible Entities: Accredited public or nonprofit private hospitals, schools of allopathic or osteopathic medicine, academically affiliated physician assistant training programs, or public or private nonprofit entities determined eligible by the Secretary.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Physicians, including family medicine, general internal medicine, general pediatrics, and combinations of these specialties • Physician assistants	• Medical school • Graduate physician assistant education • Physician residency training • Academic and community faculty development	• Support innovations in primary care curriculum development, education, and practice for physicians and physician assistants. • Community based training in medical schools, physician assistant education, residencies, and faculty development programs. • Primary care academic and community faculty development.

[34] American Academy of Family Physicians (AAFP). (Mar 12, 2012). "2012 Match Summary and Analysis". http://www.aafp.org/online/en/home/residents/match/summary.html

[35] Council on Graduate Medical Education (COGME). Twentieth Report: Advancing Primary Care. December 2010. Available at http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf. Accessed March 2012.

[36] Academic Medicine (November, 2008). History of the Title VII Section 747 Grant Programs, 1963-2008 and their impact, Vol. 83, No.11.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
		• Support development and enhancement of infrastructure in primary care academic administrative units. • Support expansion of training opportunities by funding primary care physician residency positions and physician assistant stipends.

Program Accomplishments: Grant activities funded through the PCTE program support education in primary care for physician and physician assistant (PA) students, residents, and faculty. Educational programs with a PCTE grant provide learning activities that teach knowledge and skills essential to primary care, including interprofessional education and practice, team-based clinical models, and public health. In addition, grant activities may support training in a variety of settings (e.g., hospitals, patient-centered medical homes, medically underserved communities, and community-based sites) with vulnerable populations, including homeless, chronically ill, HIV/AIDS, and older adults.

In FY 2011 (Academic Year 2011-2012), grantees of the PCTE program[37] trained a total of 18,061 physician students and residents and PA students[38] with 3,957 additional students and residents who participated in grant activities completing their training program at the end of the academic year. One out of every 3 graduates were underrepresented minorities and/or from disadvantaged backgrounds—exceeding the program's performance target of 31 percent.

Based on individual-level data reported on graduates and program completers, the PCTE program supports education programs that are producing physicians and PAs who are underrepresented minorities at higher rates than are currently in the workforce. For example, in FY 2011:

- 6.7% of PCTE Residency Training in Primary Care graduates are Hispanic, compared to 5.5% of active physicians[39]
- 21.1% of PCTE Residency Training in Primary Care program completers are Non-Hispanic Asian, compared to 12.6% of active physicians,[40]

[37] Includes Pre-Doctoral Training, Residency Training, Physician Assistant Training, and Academic Administrative Units in Primary Care grant activities.
[38] Includes students who received direct financial support (e.g., stipends, tuition support) as well as students enrolled in or trained through the academic program supported by the grant.
[39] Diversity in the Physician Workforce: Facts and Figures 2010. Retrieved from https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf
[40] Diversity in the Physician Workforce: Facts and Figures 2010. Retrieved from https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf

- 7% of PCTE Residency Training in Primary Care program completers are Non-Hispanic African American or Black, compared to 6.3% of active physicians.[41]
- 19% of Physician Assistant Training in Primary Care graduates are Hispanic, compared to 6% of current PAs.[42]

Analysis of performance data for FY 2011 (Academic Year 2011-2012) showed a number of areas where the Primary Care Training and Enhancement (PCTE) program is achieving success and also identified opportunities for strengthening specific grant activities. For example, 52% of physician and PAs received training in a medically underserved area in FY 2011. While the composite target of 59% was not met, further analysis identified important distinctions between professions. Residents were more likely to receive training in an underserved area (3 out of 4) compared to PAs (1 out of 2). Similarly, the overall proportion of graduates and completers of PCTE programs who entered practice in medically underserved areas was 35%, not meeting the target of 45%. Further analysis showed that physicians who completed a residency program in Academic Year 2011-2012 with a PCTE: Residency Training in Primary Care grant were more likely to practice in an underserved setting (1 out of 2) than PAs graduating from a program with a PCTE: Physician Assistant Training in Primary Care grant (1 out of 5).

Two additional grant programs funded in 2010 and continue through 2015 to increase the number of physician and PA students trained in primary care. In FY 2011, the Primary Care Residency Expansion (PCRE) program added an additional 164 residents to existing primary care residency programs and the Expansion of Physician Assistant Training (EPAT) program added an additional 172 PA students to existing PA education programs. The first class of PCRE program completers will complete their residency training in Academic Year 2013-2014, supported with FY 2010 funding. The first class of EPAT graduates will complete their studies in Academic Year 2012-2013, supported with FY 2012 funding.

Funding History

FY	Amount
FY 2010	$38,923,000
FY 2010 (PPHF)	$198,122,000
FY 2011	$39,036,000
FY 2012	$38,962,000
FY 2013	$39,200,000
FY 2014	$50,962,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), program oversight activities, the Advisory Committee on Training in Primary Care

[41] Diversity in the Physician Workforce: Facts and Figures 2010. Retrieved from https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf

[42] American Academy of Physician Assistants (2010). Physician Assistant Census Report: Results from the 2010 AAPA Census. Retrieved from http://www.aapa.org/uploadedFiles/content/Research/2010%20Census%20Report%20National%20_Final.pdf

Medicine and Dentistry, and the Council on Graduate Medical Education, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $50,962,000. The FY 2014 Request is $12,000,000 above the FY 2012 Enacted level. This request will fund activities that will improve the quality of primary care providers, increase the capacity of physician assistant (PA) education programs, promote interprofessional practice, enhance medical education through curriculum innovation and improve the distribution and diversity of the healthcare workforce. Through these activities, the PCTE programs will improve primary care quality and increase the appeal of primary care to students and current practitioners.

The FY 2014 Request includes a PA expansion initiative that will fund the training of 1,400 additional PA students when sustained over five years (FYs 2014-2018). Under this Request, 24 new PCTE: Physician Assistant Training in Primary Care grants will develop the program infrastructure and faculty development curricula necessary to improve teaching quality at clinical sites, establish new clinical training sites, and train an additional 60 PA students over five years. Grant awards will target programs that demonstrate ability to increase and diversify clinical training sites, improve clinical teachers' effectiveness and skills, and increase the number of students trained.

To support the 24 grantees' ambitious activities, learning communities will be established and led by an additional 4 PA education programs with expertise in expanding class sizes, strong clinical teaching, building community partnerships, and faculty development. These four programs will work closely with HRSA to achieve objectives defined by their cooperative agreement. They will lead learning communities of PCTE Physician Assistant Training in Primary Care grantees, mentor grantees and help them develop, implement, and evaluate their strategies to increase the number of students trained, diversify clinical training sites, build new community partnerships, and improve the effectiveness of community and academic clinical faculty. Funding will support clinical experiences in rural and underserved areas and collaboration with physician primary care residency programs to enhance interprofessional education and practice, with an aim to increase the number and percentage of graduates entering primary care. Faculty development will be encouraged by supporting instruction on learning theory, teaching strategies, competency assessment, cultural competency, and new models of care (including interprofessional, team-based care and patient-centered medical home), for clinicians supervising and teaching students.

Outputs and Outcomes Tables

The PCTE program supports primary care workforce growth and diversification, curricular innovations, and development of academic infrastructure. The current outcome measures reflect these objectives. As PCTE awards continue to emphasize new and evidence-based education strategies such as interprofessional education and care, community based practice experience, and education responsive to learners' and patients' needs, the evaluation and outcome measures are adjusted accordingly. Effective September 2012, grantees reported new performance

measures that better assess grant impact. New measures include individual level data on specialty and practice setting selection, and details of didactic, clinical, and research training.

Measure	Year and Most Recent Result[43] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of primary care physicians receiving training through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding: Primary Care Residency Expansion (PCRE)[44]	--	344	500	+156
Number of primary care physician assistants receiving training through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding)Physician Assistance Expansion (EPAT)[45]	--	280	323	+43
6.I.C.3.a: Number of primary care physicians who complete their education through HRSA's Bureau of Health Professions Programs supported with Prevention and Public Health funding (PCRE) (cumulative) [46]	--	--	332	+164
6.I.C.3.b: Number of physician assistants who complete their education	--	140	420	+140 per year

[43] The most recent result is for Academic Year 2011-2012 and funded in FY 2011.
[44] PCRE grantees did not matriculate residents until the 2011-2012 academic year. 1st graduating class will be in Academic Year 13-14, supported with FY 2013 funding.
[45] EPAT grantees did not matriculate residents until the 2011-2012 academic year. 1st graduating class will be in Academic Year 12-13, supported with FY 2012 funding.
[46] PCRE grantees did not matriculate residents until the 2011-2012 academic year. 1st graduating class will be in Academic Year 13-14, supported with FY 2013 funding.

Measure	Year and Most Recent Result[43] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
through HRSA's Bureau of Health Professions Programs supported with Prevention and Public Health funding (EPAT) (cumulative) [47]				
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	52% Target: 59% (Target Not Met)	59%	52%	-7 percentage points%
Percent of physician and physician assistant graduates who practice in medically underserved areas	35% Target: 45% (Target Not Met)	45%	35%	-10 percentage points
Number of graduates and program completers	3,957 Target: 7,600 (Target Not Met)	7,500	3,900	-3,600
Percent of graduates and program completers who are minority and/or from disadvantaged backgrounds	36% Target: 31% (Target Exceeded)	30%	35%	+5 percentage points
6.I.C.8: Number of Primary Care Patient Encounters[48]	182,723 Target: 30,000 (Target Exceeded)	30,000	180,000	+150,000

[47] EPAT grantees did not matriculate residents until the 2011-2012 academic year. 1st graduating class will be in Academic Year 12-13, supported with FY 2012 funding.
[48] Includes Residency Training in Primary Care and Physician Assistant Training in Primary Care programs.

Grant Awards Table – Physician Training Grants
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	143	145	145
Average Award	$220,000	$219,000	$217,000
Range of Awards	$111,000- $487,000	$93,000-$491,000	$90,000-$492,000

Grant Awards Table – Physician Assistant Training Grants
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	29	29	57
Average Award	$150,000	$155,000	$340,000
Range of Awards	$93,000-$220,000	$94,000-$219,000	$95,000-$700,000

Oral Health Training Programs

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$32,392,000	$32,919,000	$32,392,000	---
FTE	2	2	2	---

Authorizing Legislation: Sections 748 and 340G of the Public Health Service (PHS) Act

FY 2014 Authorization: Section 748……Such Sums as Necessary
Section 340G…….……...Expired

Allocation Method: ……..…Competitive Grant/Contract

Program Goal and Description: The Oral Health Training Programs are designed to increase access to culturally competent, high quality dental health services to rural and other underserved communities by increasing the number of oral healthcare providers working in underserved areas and improving training programs for oral health care providers. The Oral Health Training Programs are comprised of the following:

- Training in General, Pediatric, Public Health Dentistry and Dental Hygiene Program - provides funding in the form of grants or contracts to plan, develop, and operate, or participate in, approved professional training programs in the fields of general, pediatric, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees.

- State Oral Health Workforce Improvement Program - awards grants to States to help them develop and implement innovative programs to address the dental workforce needs of designated Dental Health Professional Shortage Areas (D-HPSAs) in a manner that is appropriate to the states' individual needs. There are twelve specific available activities listed in the authorizing legislation for this program and a thirteenth that allows the Secretary to fund innovative projects that are not specified in the law.

Need: Oral health is an essential component of overall health status, and poor oral health. Untreated oral diseases and conditions can have significant impacts on quality of life. Yet, according to a July 2011 study published by the Institute of Medicine (IOM) entitled, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations,*[49] vulnerable and underserved populations face persistent and systemic barriers to accessing oral health care. These barriers are numerous and complex and include social, cultural, economic, structural, and geographic factors, among others. The IOM Report specifically indicates that:

[49] Institute of Medicine and National Research Council. *Improving access to oral health care for vulnerable and underserved patients*. Washington, DC: The National Academies Press, 2011.

- In 2008, 4.6 million children did not obtain needed dental care because their families could not afford it.
- In 2011, there were approximately 33.3 million underserved individuals living in D-HPSAs.
- In 2006, only 38 percent of retired individuals had dental coverage.

For the first time, the Healthy People ten-year goal setting effort has identified Oral Health as a leading health indicator for 2020 (http://healthypeople.gov/2020/default.aspx).

A large proportion of dental school faculty and practicing dentists are nearing retirement age and will soon leave the workforce without adequate replacements to meet the growing the oral health needs of the U.S. population. Additional challenges to improving access to oral health services include the lack of coordination and integration of oral health, public health, and medical health care systems.

Discipline	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Training in General, Pediatric, and Public Health Dentistry	$20,048,000	$20,470,000	$20,646,000
State Oral Health Workforce Improvement	$12,344,000	$12,449,000	$11,746,000

Training in General, Pediatric, and Public Health Dentistry

The Training in General, Pediatric, and Public Health Dentistry program aims to increase the number of dental students, residents, practicing dentists, dental faculty, dental hygienists, or other approved primary care dental trainees qualified to practice in general, pediatric and dental public health fields and thus increase access to oral health care.

Eligible Entities: Schools of dentistry, public or non-profit private hospitals, and public or non-profit private entities that have approved residency or advanced education programs and others determined eligible by the Secretary.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• General dentists • Pediatric dentists • Public health dentists • Dental hygienists	• Dental Hygiene Training Programs • Undergraduate • Graduate School (dental schools) • Pre- and Post-Doctoral Programs • Residency	• Funds to plan, develop and operate or participate in approved dental training programs in the fields of general, pediatric or public health dentistry. • Provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need and are participants in any such program and who

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
	Programs	plan to work in the practice of general, pediatric, or public health dentistry or dental hygiene. • Provide traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric or public health dentistry. • Provide loan repayment to individuals who agree to serve as full-time dental faculty members in exchange for repayment of outstanding student loans based on each year of service. • Partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), the Oral Health Training Programs (including the Training in General, Pediatric, and Public Health Dentistry program and the State Oral Health Workforce Improvement Grant Program) trained over 2,700 oral health students[50]—exceeding the programs' performance target of 1,800 by 55%. Among students trained, grantees of the oral health training programs were able to train 632 primary care dental residents—exceeding the performance target of 534 by 18%. Further data analysis of individual-level data showed that 46% of graduates and program completers of oral health programs were underrepresented minorities and/or from disadvantaged backgrounds.

Results from the analysis of data reported on the training of pre- and post-doctoral oral health students showed that 1 out of every 2 sites used for clinical training were located in medically underserved communities and/or dental health professional shortage areas. Results also showed that 60% of sites used for clinical trainings used interprofessional approaches for clinical training that primarily consisted of a team of dentists, dental assistants, and dental hygienists.

Lastly, a total of 175 faculty members were trained through the faculty development activities funded by oral health training programs. In addition, a total of 35 faculty members received loan repayments in FY 2011—exceeding the performance target of 28 by 25%. Further analysis of individual-level data showed that 45% of faculty members trained through faculty development activities were underrepresented minorities and/or from disadvantaged backgrounds.

[50] Includes students who received direct financial support (e.g., stipends, tuition support) as well as students enrolled in or trained through academic programs supported by the grant.

State Oral Health Workforce Improvement Grant Program

The State Oral Health Workforce Improvement Grant Program—which falls under BHPr's Oral Health Training Programs—aims to enhance dental workforce planning and development to meet the unique needs of each State.

Eligible Entities: Eligible applicants include Governor-appointed, State governmental entities. A 40 percent match by the State is required for this program.

Designated Health Professions:	**Targeted Educational Levels / Oral Health Service Development[51]:**	**Grantee Activities:**
• Dentistry	• Primary and Secondary Education • Pre- and Post-Doctoral Programs • Residency Programs • Continuing Education	• Loan forgiveness and repayment provided to dentists who practice in D-HPSAs; serve as public health dentists for the Federal, State or local government; and/or provide services to patients regardless of their ability to pay. • Dental student recruitment and retention efforts. • Grants and low or no-interest student loans. • The establishment or expansion of dental residency programs. • Expand or establish oral health services and facilities for children with special needs. • Placement and support of dental trainees. • Continuing dental education. • Tele-dentistry. • Community-based prevention such as water fluoridation and dental sealants. • Programs that promote young students to pursue oral health or science professions. • Faculty recruitment programs at accredited dental training institutions. • The development of a State dental officer position or the augmentation of a State dental office. • Other activities deemed appropriate by the Secretary.

Program Accomplishments: In FY 2011, the 13 legislatively allowable activities were implemented in varying combinations across the 37 grantees of the State Oral Health Workforce Improvement Program depending on the needs of each individual state. For example, 28% of grantees provided loan forgiveness and payments to dentists, 25% of grantees focused on

[51] Varies based on grantee activities

recruitment and retention efforts for dentists and over 50% of grantees implemented community-based prevention services such as fluoridation and dental sealant programs.

Starting in FY 2012, a new series of performance measures were implemented in order to collect detailed information on each of the allowable activities. Analysis of data reported on community-based prevention efforts showed that grantees engaged in a number of critical oral health activities such as implementing 47 new water floridation systems to provide optimally fluoridated water; providing sealants to over 67,000 children; providing topical fluoridation to nearly 150,000 individuals; and providing preventive dental services to over 87,000 persons. Since data are now available for each of the activities, performance measures and related targets for the State Oral Health Workforce Improvement Program will be adjusted to better capture program performance in each area.

Funding History

FY 2010	$32,920,000
FY 2011	$32,781,000
FY 2012	$32,392,000
FY 2013	$32,919,000
FY 2014	$32,392,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $32,392,000, which is the same as the FY 2012 Enacted level. Funding at the proposed levels will allow continued funding of prior awards. These programs will increase access to culturally competent, high-quality, dental health services to rural and other underserved communities by increasing the number, and improving the diversity and distribution, of oral health care providers and improving the training programs for future oral health care providers.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[52] / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of students trained[53]	2,785 Target: 1,800 (Target Exceeded)	1,800	2,200	+400
Number of residents trained	632 Target: 534 (Target Exceeded)	534	534	Maintain
Number of faculty trained	175 Target: 190 (Target Not Met)	190	190	Maintain
Number of faculty receiving loan repayments	35 Target: 28 (Target Exceeded)	28	28	Maintain

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	59	55	55
Average Award	$345,000	$346,000	$353,000
Range of Awards	$170,000-$375,000	$91,000-$973,000	$93,000-$735,000

Grant Awards Table – State Oral Health Workforce Improvement
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	27	27	26
Average Award	$474,000	$430,000	$430,000
Range of Awards	$225,000-$505,000	$212,000-$504,000	$206,000-$500,000

[52] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.
[53] Methodology for calculating number of students was updated to include new and continuing students, as well as those who graduated during the academic year. Previous calculations erroneously did not count individuals who were students and graduated during the academic year. Does not include faculty.

Teaching Health Centers Graduate Medical Education Payment Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	---	---	---	---
FTE	4	4	4	---

Authorizing Legislation: Section 340H of the Public Health Service Act

FY 2014 Authorization .....Such Sums as Necessary
(Not to exceed $230,000,000, for the period of fiscal years 2011 through 2015)

Allocation Method .....Formula Based Payments

Program Goal and Description: The Teaching Health Centers Graduate Medical Education Payment Program (THCGME) provides funding for residency training in primary care and dentistry, emphasizing community-based, ambulatory practice. The THCGME program seeks to both bolster the primary care workforce through support for new and expanding primary care and dental residency programs and improve the distribution of that workforce into needed areas through emphasis on community-based, ambulatory practice.

Need: Poor health outcomes are linked to lack of reliable access to primary care. Rural and inner-city areas are particularly hard hit. There is good evidence that physicians who receive training in community and underserved settings tend to practice in such environments, for example Community Health Centers (CHCs).[54] Though CHCs receive Federal funding to improve access to care, they have difficulty recruiting and retaining primary care professionals.[55] The THCGME Program is designed to address primary care workforce distribution by increasing residency training in community-based settings.

To address the need to expand residency training into underserved and community-based settings, the June 2010 Medicare Payment Advisory Commission (MedPAC) report called for increasing the amount of GME time spent in non-hospital settings, changes to GME funding to meet goals such as community-based care, and increasing the diversity of the pipeline of health professionals.[56] In its 19th Report to Congress[57], the Council on Graduate Medical Education (COGME) concluded that resident physicians must be trained in environments which are more reflective of the evolving health care delivery system.

[54] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.
[55] Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: Implications for planned expansion. JAMA 2006; 295:1042-9.
[56] Report to the Congress: Aligning Incentives in Medicare (June 2010). Medicare Payment Advisory Commission. (available at http://www.medpac.gov).
[57] Enhancing Flexibility in Graduate Medical Education (September 2007), COGME Nineteenth Report, (available at http://www.cogme.gov/pubs.htm).

Teaching Health Centers (THCs) have demonstrated progress toward innovative models of patient care delivery such as the patient-centered medical home, implementation of electronic health records, population-based care management, and use of interdisciplinary team-based care.[5] The growth of THCs has been limited due to difficulty bringing together the dual mission of training and service in health centers, administrative complexity, and a lack of financial resources.[58] Successful THCs have common elements, foremost of which is an institutional commitment to a dual mission of medical education and service to an underserved patient population, including underrepresented minority and other high risk populations.

Eligible Entities: Community-based ambulatory patient care centers that operate an accredited primary care residency program in one or more of the following specialties: family medicine, general dentistry, geriatrics, internal medicine, internal medicine-pediatrics, obstetrics and gynecology, pediatrics, psychiatry, and pediatric dentistry. Eligible entities include but are not limited to: Federally Qualified Health Centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, and an entity receiving funds under Title X of the Public Health Service Act.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Family medicine • General dentistry • Geriatrics • Internal medicine • Internal medicine-pediatrics • Obstetrics and gynecology • Pediatrics • Psychiatry • Pediatric dentistry	• Residents	• Operate an accredited residency program. • Medical and dental residents in health centers will provide patient care services during their training in health centers.

Program Accomplishments:

In FY 2011, 11 THCs began receiving payments and training 63 primary care medical and dental residents in July 2011. In FY 2012, 11 additional THCs received payments for a total of 22 programs supported. In FY 2013 the program grew to a total of 40 programs and 350 residency slots. The awardees include twelve Federally-Qualified Health Centers (FQHC), one FQHC Look Alike, two Area Health Education Centers (AHEC), two Native American Health Authorities, one community mental health clinic, and twenty other community based entities. Analysis of performance data showed that nearly 45% of THC sites used to provide primary care training to residents were located in medically underserved communities and/or health professional shortage areas. Results also showed that sites used to provide clinical training

[58] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.

served a number of specialized populations including veterans and their families, older adults, as well as children and adolescents.[6]

Funding History

FY	Amount
FY 2010	---
FY 2011	$230,000,000
FY 2012	---
FY 2013	---
FY 2014	---

Funding includes costs associated with processing of payments through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $0. The FY 2014 Request is the same as the FY 2012 Enacted level. In FY 2011, the THCGME Payment Program received a $230,000,000 mandatory appropriation that is available through FY 2015.

The approximate annual training cost per resident is $150,000 (combined direct graduate medical education expenses and indirect medical education expenses). Residency training programs vary in length depending on specialty. This request assumes the majority of payments will be for primary care physicians who require three years of training. In FY 2014, $72,664,000 will support approximately 450 training positions, as well as evaluation, administrative, and oversight activities.

Outcomes and Outputs Table

Measure	Year and Most Recent Result[59] / Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
6.I.C.5: Number of primary care residents trained (Cumulative)	63 (Historical Actual)	143	450	+307

[59] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	22	40	40
Average Award	$566,000	$1,193,000	$1,725,000
Range of Awards	$75,000-$2,700,000	$75,000-$3,600,000	$75,000-$5,437,500

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$27,230,000	$30, 269,000	---	-$27,320,000
FTE	2	2	---	-2

Authorizing Legislation**:** Section 751 of the Public Health Service Act as amended by the Affordable Care Act

FY 2014 Authorization.....$125,000,000

Allocation Method.....Cooperative Agreement/Competitive Grant

Program Goal and Description: The Area Health Education Centers (AHEC) Program seeks to provide access to high quality, culturally competent health care through community-based interprofessional training, continuing education, and outreach activities that will ultimately improve the distribution, diversity, quality and supply of the primary care health professions workforce serving in rural and underserved health care delivery sites. The AHEC Program supports two types of awards: Infrastructure Development, and Point of Service Maintenance and Enhancement. The Infrastructure Development funds are used to plan, develop and implement AHEC centers that link the grantee school and at least two other disciplines with local educational and clinical sites. The Point of Service funds are awarded to AHEC programs and centers that have completed the Infrastructure Development phase to stabilize and evaluate evolving conditions that impact the outcomes of the program.

Need: The Association of American Medical Colleges projects a shortage of 45,000 primary care physicians by the end of the decade.[60] The shortage of primary care physicians will most severely impact vulnerable and underserved populations, which include approximately 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas.[61]

Eligible Entities: Public or private non-profit accredited schools of allopathic and osteopathic medicine. Accredited schools of nursing are eligible applicants in States and territories in which no AHEC Program is in operation.

[60] American Association of Medical Colleges, (2013). Statement to the Committee on Health, Education, Labor and Pensions (HELP) - Subcommittee on Primary Health and Aging. U.S. Senate. Available online at: https://www.aamc.org/download/327162/data/aamcstatementforsenatehelpsubcommitteehearingonprimarycareshort.pdf (accessed 2/11/2013)

[61] American Association of Medical Colleges, (2010). Physician Shortages to Worsen Without Increases in Residency Training, available online at https://www.aamc.org/download/286592/data/physicianshortage.pdf (accessed 2/11/2013)

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allied health • Community health workers • Dentists • Nurse midwives • Nurse practitioners • Optometrists • Pharmacists • Physicians • Physician assistants • Psychologists • Public health • Other health professions	All education levels are targeted to provide primary care workforce development for the following trainees: • Medical students • Health professions students • Continuing education for primary care providers in underserved areas • High school students (9-12)	• Plan, develop, operate and evaluate AHEC Center(s). • Address health care workforce needs in the service areas coordinating with local workforce investment boards (WIBs). • Provide clinical rotations in primary care and community-based, interdisciplinary training. • Disseminate continuing education courses for health professionals with an emphasis on underserved areas and for health disparity populations. • Promote health careers including public health in the high school grades.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of the AHEC program exceeded several of the program's performance targets. For example, grantees trained over 28,000 medical students in community sites located in rural and/or underserved areas—exceeding the program's performance target of 22,600 by 28%. Among sites used for clinical training, results showed that nearly 1 out of every 2 sites were located in a medically underserved community and/or a Health Professional Shortage Area (HPSA). Results also showed that sites used for clinical training served a number of specialized populations including children and adolescents, as well as veterans and their families. Grantees of the AHEC program also had over 380,000 trainees participate in (CE)—exceeding their performance target of 366,000 by 5%. Results showed that trainees participated in an array of CE offerings on topics ranging from informatics to health disparities. Among trainees participating in CE offerings, 16.3% were currently employed in a medically underserved community or a HPSA —exceeding the performance target of 15.3% by 6.5%.

Analysis of current and prior year performance data showed significant improvement in a number of areas between FY 2010 (Academic Year 2010-2011) and FY 2011 (Academic Year 2011-2012). For example, the overall number of medical students trained in underserved areas increased by 39% between FY 2010 (20,758) and FY 2011 (28,869). Similarly, the number of trainees participating in CE increased by 8% between FY 2010 (353,217) and FY 2011 (382,677).

Results from these analyses also showed areas where the program was unable to meet its performance target and where there are opportunities for strengthening the program activities and evaluation strategies. For example, grantees of the AHEC program were not able to meet the target regarding the number of associated health professions students trained in a rural and/or

underserved area; however, this is due to an increased focus on the training of primary care providers that began in FY 2011. Similarly, the total number of partnerships with community and/or migrant health centers and other underserved area sites decreased between FY 2010 (10,340) to FY 2011 (7,600). The observed decrease was due to a significant change in measurement. In previous years, this measure captured the number of partnerships established for the purposes of CE offerings; starting in FY 2011, this measure now captures the number of partnerships established solely for the purposes of community-based clinical training. In FY 2011, the AHEC Program grantees did not meet the targeted goal of the number of elementary and high school students receiving guidance and information in health careers. The decrease in the number of students was due to less emphasis on broad, general awareness activities targeting elementary school students and greater emphasis on fewer, but, more intensive interactions and involvement focusing on high school students.

Funding History

FY	Amount
FY 2010	$33,274,000
FY 2011	$33,142,000
FY 2012	$27,230,000
FY 2013	$30,269,000
FY 2014	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

No funding is requested in FY 2014. The FY 2014 Request is $27,230,000 below the FY 2012 Enacted level. While the AHEC Program continues to focus on exposing medical students and health professions students to primary care and practice in rural and underserved communities, there is a higher priority to allocate Federal resources to training programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program grantees will continue their efforts to provide interprofessional/interdisciplinary training to health professions students with an emphasis on primary care. These activities may be supported through other funding sources.

Outcomes and Outputs Table

Measure	Year and Most Recent Result[62] / Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
No. of medical students trained in community sites in rural/underserved areas	28,869 Target: 22,600 (Target Exceeded)	17,022	---	-17,022
No. of associated health professions students trained in community sites in rural/underserved areas	14,106 Target: 33,600 (Target Not Met)	23,260	---	-23,260
No. of training partnerships with community/migrant health centers and other underserved area sites	7,600 Target: 12,100 (Target Not Met)	8,479	---	-8,479
Number of local providers who received continuing education on topics including Cultural Competence, Women's Health, Diabetes, Hypertension, Obesity, and Health Disparities	382,677 Target: 366,000 (Target Exceeded)	289,638	---	-289,638
Percent of local providers receiving continuing education in medically underserved areas	16.3% Target: 15.3% (Target Exceeded)	12.5%	---	-12.5%
No. of elementary/high school students receiving health career guidance and information from the AHEC Programs	276,434 Target: 456,000 (Target Not Met)	426,568	---	-426,568
No. of high school students (grade 9-12) participating in $\geq$ 20 hours of health career training and/or academic enhancement experience	13,600 Target: 26,500 (Target Not Met)	15,611	---	-15,611

[62] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	58	57	---
Average Award	$436,181	$500,000	---
Range of Awards	$91,427 - $1,097,124	$102,000 - $1,648,907	---

Interdisciplinary, Community-Based Linkages

Geriatric Programs

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$30,629,000	$31,127,000	$30,629,000	---
Prevention and Public Health Fund[63] (Alzheimer's)	$2,000,000	---	$5,300,000	+$3,300,000
Total Program Level	$32,629,000	$31,127,000	$35,929,000	+$3,300,000
FTE	4	4	4	---

Authorizing Legislation: Section 753 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act

FY 2014 Authorization:
Geriatric Education Centers…….. Unspecified
Geriatric Training for Physicians, Dentists, and
Behavioral/Mental Health Professionals……. Unspecified
Geriatric Academic Career Awards…….. Unspecified

Allocation Method .....Competitive Grants/Contracts

Program Goal and Description: Geriatric programs seek to improve high quality interprofessional geriatric education and training to the health professions workforce including geriatric specialists and non-specialists. These programs focus on increasing the number of geriatric specialists and increasing geriatrics competencies in the generalist workforce to improve care for this often vulnerable, underserved population. Geriatric programs include:

- Geriatric Education Centers (GEC) Program - provides support to establish or operate GECs to train health professional faculty, students, and practitioners in the interprofessional diagnosis, treatment and prevention of disease, disability, and other health problems of the elderly. The GECs provide services to and foster collaborative relationships among health professions educators within defined geographic areas.

[63] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

- Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals (GTPD) Program - supports fellowships and other training efforts that assist physicians, dentists, and behavioral and mental health professionals who plan to teach geriatric medicine, geriatric dentistry, or geriatric behavioral and mental health.

- Geriatric Academic Career Awards (GACA) Program - promotes the development of academic clinician educators in geriatrics (including physicians, nurses, social workers, psychologists, dentists, pharmacists, and allied health professionals) by requiring them to provide clinical training in geriatrics, including training of interprofessional teams of health professionals.

Need: The Institute of Medicine identified three shortfalls that the health care system will face as the number of older Americans increases: 1) health care needs of older adults will be difficult to meet by the current health care workforce; 2) there will be severe shortages of geriatric specialists and other providers with geriatric skills; and 3) there will be increased demand for chronic care management skills.[64]

Geriatric Programs

Programs	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Geriatric Education Centers	$16,909,778	$17,708,488	$17,070,488
Geriatric Education Centers (PPHF)[65]	$2,000,000	---	$5,300,000
Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals	$8,293,373	$8,293,373	$8,293,373
Geriatric Academic Career Awards	$5,425,849	$5,265,139	$5,265,139

Geriatric Education Centers Program

The Geriatric Education Centers (GECs) program—which falls under BHPr's Geriatric Programs—aims to provide high quality interprofessional geriatric education and training to the health professions workforce including geriatric specialists and non-specialists.

Eligible Entities: Accredited schools of multiple health disciplines.

[64] Institute of Medicine. Retooling for an Aging America: Building the Health Care Workforce. Washington, DC: The National Academies Press; 2008.

[65] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied health • Allopathic medicine • Behavioral and mental health • Chiropractic • Clinical psychology • Clinical social work • Dentistry • Health administration • Marriage and family therapy • Nursing • Optometry • Osteopathic medicine • Pharmacy • Physician assistant • Podiatric medicine • Professional counseling • Public health • Veterinary medicine	• Undergraduate • Graduate • Post-graduate • Practicing health care providers • Faculty	• Interprofessional geriatric education and training to students, faculty and practitioners. • Curricula development relating to the treatment of the health problems of elderly individuals. • Faculty development in geriatrics. • Continuing education for health professionals who provide geriatric care. • Clinical training for students in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), GEC grantees trained over 79,000 healthcare providers—exceeding the program's performance target of 59,413 by 34%. Analysis of performance data also showed that, of the total number of providers trained, over 60,000 were reached through continuing education CE offerings. Grantees of the GEC program delivered approximately 3,300 CE offerings and provided over 43,000 total hours of instruction in FY 2011. Results also showed that almost 3 out of every 4 CE offerings were interprofessional in focus. Grantees of the GEC program also offered over 800 clinical training sessions to a total of over 18,000 trainees. Results from the analysis of data reported on these trainings showed that nearly 3 out of every 4 sites used to deliver clinical training were located in medically underserved community and/or Health Professional Shortage Area (HPSA).

Differences in targets and actuals are due to a change in the methodology for calculating the total number of trainees. Previously, the number of students completing a training program was excluded from the total number of individuals trained during any given academic year. Since program completers and/or graduates receive training during the academic year, counts have been adjusted to include these individuals and account for the large increase in the number of providers receiving training between FY 2010 (62,160) and FY 2011 (79,521).

Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals

The Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals program—which falls under BHPr's Geriatric Programs—aims to increase the supply of quality, culturally competent geriatric faculty and to retrain mid-career faculty in geriatrics.

Eligible Entities: Accredited schools of medicine, schools of osteopathic medicine, teaching hospitals, and graduate medical education programs.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**

• Dentistry
• Medicine
• Counseling
  - Marriage & family
  - Professional
  - Substance abuse
• Osteopathic medicine
• Psychology
• Psychiatric nursing
• Psychiatry
• Social work
	• Graduate
	• Post-graduate
	• Faculty
		• Provide intensive one-year mid-career faculty retraining and two-year fellowship training in geriatrics.
		• Provide training in and exposure to the physical and mental disabilities of elderly individuals through a variety of service rotations, such as, geriatric consultation services, acute care services, dental services, geriatric behavioral or mental health units, day and home care programs, rehabilitation services, geriatric ambulatory care and comprehensive evaluation units, and community care programs for elderly individuals with developmental disabilities.
		• Apply contemporary educational delivery methods to interprofessional audiences.
		• Demonstrate application of administrative, clinical, teaching, and research skills as academic and clinical faculty.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), there were 63 fellows of the Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professionals (GTPD); of these, 15 fellows were dentists, 1 fellow was a clinical psychologist, 17 fellows were psychiatrists, 29 fellows were geriatric medicine physicians, and 1 fellow was an internal medicine physician. Analysis of performance data showed that, in FY 2011, fellows reported a total of 23,358 patient encounters with older adults.

Differences in targets and actuals are due to a change in the methodology for calculating the total number of trainees. Previously, the number of students completing a training program was excluded from the total number of individuals trained during any given academic year. Since program completers and/or graduates receive training during the academic year, counts have been adjusted to include these individuals and, therefore, accounts for the increase in actuals between FY 2010 (45) and FY 2011 (63).

Geriatric Academic Career Awards Program

The Geriatric Academic Career Awards (GACA) program—which falls under BHPr's Geriatric Programs—aims to promote the development of academic clinician educators who provide clinical training in geriatrics.

Eligible Entities: Eligible entities are schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy or other allied health disciplines in an accredited health professions school.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
Allied health Allopathic medicine Dentistry Nursing Osteopathic medicine Pharmacy Psychology Social work	• Faculty	• Promote the career development of junior faculty as academic geriatric specialists. • Provide training in clinical geriatrics, including training of interprofessional teams of health professionals. • Provide junior faculty with release time to focus on teaching activities such as interprofessional geriatric curricula development and integrating geriatrics into health professions curricula.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), the GACA program funded 66 full-time junior faculty. Among awardees, 61 were faculty in Geriatric medicine; 3 were faculty in geriatric psychiatry; 1 was faculty in clinical psychology; and 1 was faculty in physical therapy. Results from the analysis of performance data showed that awardees of the GACA program delivered over 1,000 interprofessional continuing education courses specific to geriatric-related topics to over 44,000 students and providers. Collectively, awardees of the GACA program delivered a total of 32,000 hours of instruction through continuing education courses. In addition to continuing education courses, awardees of the GACA program provided over 4,700 clinical trainings during Academic Year 2011-2012 to providers of many professions and disciplines including, but not limited to, allopathic medicine, nursing, behavioral health, and pharmacy.

Funding History

FY	Amount
FY 2010	$33,675,000
FY 2011	$33,542,000
FY 2012	$30,629,000
FY 2012 (PPHF)	$ 2,000,000
FY 2014	$30,629,000
FY 2014 (PPHF)	$ 5,300,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $35,929,000. The FY 2014 Request is $3,300,000 above the FY 2012 Enacted level. This request will fund continuation support for 45 Geriatric Education Center cooperative agreements, 12 Geriatric Training for Physician, Dentists, and Behavioral and Mental Health Professional grants, and 63 Geriatric Academic Career Awards. This funding level also supports 45 Geriatric Education Centers to provide interprofessional continuing education to health professionals on Alzheimer's disease. The amount of the award for GACA recipients is statutorily required to reflect any annual increases in the Consumer Price Index. However, award amounts to the GEC and GTPD programs are subject to reductions in their continuation funding if there is a reduction in available funding. In FY 2012 the cost of living adjustment (COLA) was 3.6 percent. The COLA for FY 2013 will be 1.7 percent.

Outcomes and Outputs Tables

The table below includes some performance measures that are still under development since the Alzheimer's education activities have only recently been initiated and baselines have not yet been established.

Measure	Year and Most Recent Result[66]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of health care providers receiving training through the GEC Program	79,521[67] Target: 59,413 (Target Exceeded)	Target: 59,413	Target: 79,521	+20,099
6.I.C.12: Number of BHPr-sponsored interprofessional	---	---	TBD	---

[66] Most recent result is the Academic Year 2011-2012 and funded in FY 2011.

[67] Methodology for calculating number of trainees was updated to include new and continuing students, as well as those who completed the program during the academic year. Previous calculations erroneously did not count individuals who were students and completed their requirements during the academic year.

Measure	Year and Most Recent Result[66]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
continuing education sessions provided on Alzheimer's disease (Developmental)[68]				
6.I.C.13: Number of health care providers participating in interprofessional continuing education on Alzheimer's disease (Developmental) [69]	---	---	TBD	---
Number of GTPD Fellows	63[70] Target: 45 (Target Exceeded)	45	63	+18
Number of GACA Awardees	66 Target: 68 (Target Not Met)	68	63	-5

Grant Awards Table – Geriatric Education Centers Program
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	45	45	45
Average Award	$362,669	$362,266	$362,266
Range of Awards	$200,000-$403,000	$200,000 - $403,000	$200,000 - $403,000

[68] Baseline for this measure will be in FY 2014.
[69] Baseline for this measure will be in FY 2014.
[70] Methodology for calculating number of fellows was updated to include new and continuing fellows, as well as those who completed the program during the academic year. Previous calculations erroneously did not count individuals who were fellows and completed their requirements during the academic year.

Grant Awards Table – Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	13	12	12
Average Award	$679,268	$679,268	$679,268
Range of Awards	$551,000 - $1,360,000	$551,000 - $1,360,000	$551,000 - $1,360,000

Grant Awards Table – Geriatric Academic Career Awards Program
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	65	63	63
Average Award	$77,691	$79,012	$80,355
Range of Awards	---	---	---

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training Programs

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$2,892,000	$2,939,000	$2,892,000	---
Prevention and Public Health Fund[71]	$10,000,000	---	---	-$10,000,000
Total Program Level[72]	$12,892,000	$2,939,000	$2,892,000	-$10,000,000
FTE	2	2	2	---

Authorizing Legislation: Sections 755(b)(1)(J) and 756 of the Public Health Service Act.

FY 2014 Authorization: $35,000,000

Allocation Method: .....Competitive Grant/Contract

Program Goal and Description: The Mental and Behavioral Health Education and Training Programs work to close the gap in access to mental and behavioral health care services by increasing the number of adequately prepared mental and behavioral health (including substance abuse) providers. This funding includes support for two grant programs:

- Mental and Behavioral Health Education and Training (MBHET) Grant Program - Funds accredited schools and programs of social work and accredited graduate psychology schools and programs to strengthen the clinical field competencies of social workers and psychologists who pursue clinical service with high need and high demand populations.

- Graduate Psychology Education (GPE) Program - Funds accredited health profession schools, universities, and other public or private nonprofit entities to plan, develop, operate, or maintain doctoral psychology schools and programs in mental and behavioral health practice to train psychologists to work with underserved populations. The program is designed to foster an integrated and interprofessional approach to addressing access to behavioral health care for vulnerable and underserved populations.

[71] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.
[72] The FY 2014 Budget includes a one year, $35 million initiative to expand the mental and behavioral health workforce in SAMHSA, through a partnership with HRSA.

Need: Mental disorders rank in the top five chronic illnesses in the U.S. The National Alliance on Mental Illness reported approximately six percent, or one in 17 Americans suffers from a serious mental illness.[73] Serious mental illnesses cost society approximately $193.2 billion in lost earnings per year. Individuals suffering from a serious mental illness earned at least 40 percent less than people in good mental health, confirming that mental disorders contribute to significant losses of human productivity.[74]

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Mental and Behavioral Health Education and Training Grant Program [75]	$10,000,000	---	---
Graduate Psychology Education Program	$2,892,000	$2,939,000	$2,892,000

Mental and Behavioral Health Education and Training Grant Program

The MBHET Grant Program—one of two grant programs within BHPr's Mental and Behavioral Health Education and Training Programs—aims to increase the supply of mental and behavioral health professionals who pursue clinical work with high need and high demand populations. High need and high demand refers to vulnerable, rural, underserved, veterans, military personnel, and their families, as well as children and adolescents.

Eligible Entities: Eligible entities vary according to the statutory purpose for which the application is submitted.

[73] National Alliance on Mental Illness. (2008). What is Mental Illness? Mental Illness Fact Sheet, November 4, 2008.

[74] Kessler, R.C., Heeringa, S., Lakoma, M.D., Petukhova, M., Rupp, A.E., Schoenbaum, M., Wang, P.S., and Zasavslu. A.M. (2008). The individual-level and societal-level effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. American Journal of Psychiatry; June; 165(6): 703-711.

[75] The FY 2014 Budget includes a one year, $35 million initiative to expand the mental and behavioral health workforce in SAMHSA, through a partnership with HRSA.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Social work (Master's level) • Psychologists (Masters level, which includes clinical, counseling, marriage and family therapy)	• Accredited Graduate Social Work (MSW) Schools and Programs • Accredited Graduate Psychology (Masters level) Schools and Programs (clinical, counseling, marriage and family therapy)	• Provide interprofessional education and clinical training of designated disciplines in the mental health workforce. • Engage in recruitment, education, and clinical training of graduate social work and psychology students. • Increase the number of enrolled graduate students pursing clinical training with high need and high demand populations and in child and adolescent mental health. • Establish or expand clinical training for students committed to working with high need and high demand populations including rural, vulnerable, and/or underserved populations, veterans, military personnel and their families, and children and adolescents.

Program Accomplishments: The MBHET Grant Program is a new program that was implemented in FY 2012. The program recruited master of social work and doctoral-trained psychology students. HRSA estimates that funded grants will support approximately 280 students in internships and field placements working with high need and high demand populations over the three year budget period. The performance measures for this program will include the collection of individual level data to permit program to determine student demographics, number of graduates, and related internships and field experiences.

Graduate Psychology Education Program

The Graduate Psychology Education (GPE) program—which falls under BHPr's Mental and Behavioral Health Education Programs—aims to increase the supply of doctoral-trained psychologists prepared to address the behavioral health needs of vulnerable and underserved populations.

Eligible Entities: Eligible entities include accredited psychology programs within institutions of higher education, and other public or private non-profit entities. Applicants must demonstrate that the training within an accredited graduate program in clinical psychology will occur in collaboration with two or more disciplines other than psychology.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Graduate Psychology (doctoral)	• Accredited Graduate Psychology (Doctoral level) Schools and Programs • Accredited internships in public and private nonprofit institutions	• Provide integrated and interprofessional education and clinical training leading to a doctoral degree in psychology. • Increase access to quality behavioral health services to vulnerable, underserved, and needy populations. • Increase the number of prepared psychologists with doctoral degrees. • Collect, analyze, and synthesize data.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of the GPE program trained over 900 students.[76] Results from the analysis of performance data showed that, among students trained in FY 2011, 110 graduated from the program. Analysis of demographic data provided by grantees about students who graduated during this academic year showed that 55% were underrepresented minorities and/or from disadvantaged backgrounds and 29% reported practicing in a medically underserved area following graduation. Results also showed that approximately 1 out of every 2 training sites used to provide psychology students with clinical training were located in medically underserved communities and/or Health Professional Shortage Area. Sites used for clinical training served a number of specialized populations including children and adolescents, individuals with substance use disorders, as well as veterans and their families.

Differences in targets and actuals for FY 2011 are due to a change in the methodology for calculating the total number of trainees. Previously, the number of students completing a training program was excluded from the total number of individuals trained during any given academic year. Since program completers and/or graduates receive training during the academic year, counts have been adjusted to include these individuals and, as a result, account for the large difference in the number of students trained between FY 2010 (620) and FY 2011 (938).

[76]Includes students who received direct financial support (e.g., stipends, tuition support) as well as students enrolled in or trained through the academic program supported by the grant.

Funding History

FY	Amount
FY 2010	$2,939,000
FY 2011	$2,927,000
FY 2012	$2,892,000
FY 2012 (PPHF)	$10,000,000
FY 2013	$2,939,000
FY 2014	$2,892,000
FY 2014 (PPHF)	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $2,892,000. The FY 2014 Request is $10,000,000 below the FY 2012 Enacted level. This funding will support the GPE program. The FY 2014 Request for the GPE Program will fund 25 grantees and train 700 students and 105 graduates in doctoral level psychology schools, programs and pre-degree internships.

In FY 2014, SAMHSA will provide funding and partner with HRSA in expanding the MBEHT Grant Program. This expansion will increase the clinical service capacity of the behavioral health workforce by supporting training for masters level social workers, psychologists and marriage and family therapists as well as behavioral health paraprofessionals. This effort is critical to ensure that the mental and behavioral health workforce is able to meet the needs of high need and high demand populations, including rural, vulnerable, and underserved populations. In FY 2014, the program will include an emphasis on training to address the needs of children, adolescents, and transition-age youth (ages 16-25) and their families. The FY 2014 SAMHSA-HRSA expansion of the MBHET grant program will fund approximately 120 grants of up to $325,000, and will increase the behavioral health workforce by 3,950.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[77] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Graduate Psychology Education				
Number of Trainees	938 Target: 614 (Target Exceeded)	614	875	+261
Number Graduates	110 Target: 90 (Target Exceeded)	90	105	+15
Number of Graduates entering practice in MUCs	32 Target: 75 (Target Not Met)	75	32	-43
Percent of Graduates entering practice in MUCs	29% Target: 83% (Target Not Met)	83	29	-54
Mental and Behavioral Health Education and Training Grant Program				
6.I.C.16: Number of students receiving training via clinical Internships in Psychology or Field Placements in Social Work focused on working with high need and high demand populations.[78] (Developmental)	---	---	TBD	---

[77] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.
[78] Baseline for this measures will be in FY 2014.

6.I.C.17: Number of graduates entering practice with high need and high demand populations [79](Developmental)	---	---	TBD	---
6.I.2: Percent of graduates entering practice with high need and high demand populations[80] (Developmental)	---	---	TBD	---

Grant Award Table - Mental and Behavioral Health Education and Training Grant Program
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	20	---	---
Average Award	$480,275 (for a three year budget period)	---	---
Range of Awards	$480,275 (for a three year budget period)	---	---

Grant Award Table - Graduate Psychology Education
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	20	20	20
Average Award	$134,141	$137,000	$137,000
Range of Awards	$91,571 - $173,840	$80,000 - $190,000	$80,000 - $190,000

[79] Baseline for this measure will be in FY 2014.
[80] Baseline for this measure will be in FY 2014.

Public Health Workforce Development
Public Health and Preventive Medicine

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$8,144,000	$8,243,000	$3,226,000	-$4,918,000
Prevention and Public Health Fund[81]	$25,000,000	---	$4,776,000	-$20,224,000
Total Program Level	$33,144,000	$8,243,000	$8,002,000	-$25,142,000
FTE	3	3	3	---

Authorizing Legislation: Sections 765, 766, 767 and 768 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization……..Unspecified

Funding Allocation.....Competitive Grant

Program Goal and Description: The Public Health and Preventive Medicine program includes funding for the following grant programs:

- Public Health Training Centers (PHTC) Program - Funds schools of public health and other programs that provide graduate or specialized training in public health to expand and enhance training opportunities focused on the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce. Education and training provided by the PHTC Program reflect the core public health competencies as defined by the Council on Linkages between Academia and Public Health Practice. Examples of training topics addressed by the PHTCs include environmental health, public health science, designing surveillance systems, electronic data collection, and risk communication.

- Public Health Traineeship (PHT) Program - Provides grants to accredited institutions for the provision of graduate or specialized training in public health through traineeships for students in biostatistics, epidemiology, environmental health, toxicology, nutrition, or maternal and child health.

[81] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

- Preventive Medicine Residency (PMR) Program - Supports post-graduate physician training by funding the planning, development, operation, or participation in approved residency programs in preventive medicine and public health. Preventive medicine physicians are uniquely trained in both clinical medicine and public health in order to promote, and maintain health and well-being and reduce the risks of disease, disability, and death in individuals and populations.

- Integrative Medicine Program (IMP) - IMP grants: (1) incorporate evidence-based integrative medicine content into existing preventive medicine residency programs; (2) provide faculty development to improve clinical teaching in both preventive and evidence-based integrative medicine; and (3) facilitate delivery of related information that will be measured through competency development and assessment of the trainees.

Need: The strength of the public health system rests on its ability to deliver essential public health services, and a capable and qualified public health workforce is a key factor in an organization's ability to deliver those essential services**.** Public health workers protect and improve the health of communities through education, disease prevention and health promotion, monitoring, diagnosis, research, and provision of services to address community health problems. A shortage of experienced public health professionals equipped to address the growing burden of chronic disease in this country is predicted.[82] In addition, the Institute of Medicine's Committee on Training Physicians predicts a shortage of physicians in public health careers.[83] Public health workers need foundational training in core public health skills and competencies as well as education and training to maintain and upgrade their skills.

Program	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Public Health Training Centers Program	--	$5,580,748	$3,226,000
Public Health Training Centers (PPHF)	$23,893,000	--	$2,191,510
Public Health Traineeships	$829,000	--	--
Public Health Traineeships (PPHF)	$1,107,000		
Preventive Medicine Residency Program (PPHF)	--	--	$2,584,490

[82] Bodenheimer T, Chen E, Bennett HD. Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job? *Health Affairs* January 2009 vol. 28 no. 1 64-74.

[83] Institute of Medicine. Committee on Training Physicians for Public Health Careers. *Training Physicians for Public Health Careers.* The National Academies Press. 2007

Preventive Medicine Residency Program	$3,813,000	$2,662,252	--
Integrative Medicine Program	$3,502,000	--	--

The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Public Health Training Centers Program

The Public Health Training Centers (PHTC) program—which falls under BHPr's Public Health and Preventive Medicine program—aims to strengthen the workforce in state, local, and Tribal health departments to improve the capacity and quality of a broad range of public health personnel to carry out core public health functions and essential public health services.

Eligible Entities: Accredited schools of public health or other public or nonprofit private institutions accredited for the provision of graduate or specialized training in public health.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Public health workforce including nurses, physicians, dentists, veterinarians, social workers, epidemiologists, nutritionists, sanitarians, and others.	• Graduate public health professionals students • Existing public health professionals at all levels in the workforce	• Provide graduate or specialized training in public health in the areas of preventive medicine, health promotion and disease prevention, and improve access to and quality of health services in medically underserved communities. • Establish or strengthen field placements for students. • Involve faculty and students in collaborative projects to enhance public health services to medically underserved communities. • Assess the health personnel needs of the service area and assist in the planning and development of training programs to meet such needs.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of the PHTC program delivered over 14,800 continuing education offerings to over 160,000 trainees, some attending multiple trainings. In total, grantees of the PHTC program delivered over 34,000 hours of instruction—averaging 2 hours of instruction and 11 trainees per offering. Performance data for FY 2011 showed that grantees of the PHTC program focused continuing education efforts in increasing competency of the public health workforce in the areas of Analytics/Assessment and Public Health Sciences. Results also showed that approximately 1 out of every 2 trainings were interprofessional and that professions most often reached by grantees of the PHTC program included public health nurses, registered nurses, health educators, and epidemiologists.

In accordance with legislative requirements, all grantees of the PHTC program continued their needs assessment process to determine the training needs of public health workers in their geographically designated areas. Grantees of the PHTC program also fulfilled the legislative

requirement of establishing and strengthening field placements of public health students. During FY 2011, grantees of the PHTC program placed a total of 1,768 public health students. Performance data showed that 48% of field placements were in a medically underserved community and/or health professions shortage area and that nearly 1 out of every 4 students placed were underrepresented minorities and/or from disadvantaged backgrounds. Lastly, 81% of students placed successfully completed their requirements and nearly 4 out of every 5 program completers indicated an intent to work in a medically underserved community.

Trends in performance for the PHTC program highlighted several areas of success for the program. For example, while the overall number of public health workers participating in continuing education decreased between FY 2010 (185,266) and FY 2011 (161,780), the total number of continuing education offerings increased nearly six-fold from FY 2010 (2,431) to FY 2011 (14,813). It is important to note how advances in technology and social media continue to shape how the workforce is trained and, similarly, affect how training efforts can be measured. A recent analysis of performance data revealed that only 30% of the 15,532 hours of instruction offered in FY 2010 were delivered through distance learning; however, nearly 75% of the 34,523 hours of instruction offered in FY 2011 were delivered through distance learning—an increase of 150%. Challenges continue to emerge regarding the methodology and parameters for measuring and tracking continuing education offered through new and innovative platforms such as social media. Performance targets for FY 2014 and beyond were, to the extent possible, adjusted to reflect the growing use of distance learning for continuing education purposes.

Public Health Traineeship Program

The Public Health Traineeship (PHT) program—which falls under BHPr's Public Health and Preventive Medicine program—aims to increase the number of professionals trained in public health fields of which there is a shortage in the United States.

Eligible Entities: Schools of public health, other public or nonprofit private entities accredited by the Council on Education for Public Health, and other public or nonprofit private institutions.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Public health workforce in the designated public health shortage fields.	• Graduate (Master's and doctoral)	• Support graduate education in public health in the fields of epidemiology, environmental health, biostatistics, toxicology, nutrition, and maternal and child health. • Award traineeships to individuals to provide for tuition, fees, stipends, and allowances for reasonable living expenses.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), grantees of the PHT program supported a total of 350 public health students; of these, 98 graduated during that year. The median financial award amount for students supported through the PHT program was $1,940. Among students who graduated and received direct financial support through the PHT program, 46% were underrepresented minorities and/or from disadvantaged backgrounds and

approximately 2 out of every 5 graduates indicated an intention to enter practice in a MUC and/or HPSA.
The total number of students supported by grantees of the PHT program decreased between FY 2010 (501) and FY 2011 (350). Grantees of the PHT program have moved toward providing larger financial award amounts to fewer students in order to support successful completion of a graduate-level academic program in public health.

Preventive Medicine Residency Program

The Preventive Medicine Residency (PMR) program—which falls under BHPr's Public Health and Preventive Medicine program—aims to increase the number of preventive medicine physicians in public health specialties.

Eligible Entities: Accredited schools of public health, allopathic or osteopathic medicine; accredited public or private nonprofit hospitals; state, local or Tribal health departments or a consortium of two or more of the above entities.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Preventive medicine physicians	• Residency training	• Plan and develop new residency training programs. • Maintain or improve existing residency programs. • Provide financial support to residency trainees. • Plan, develop, operate, and/or participate in an accredited residency program. • Establish, maintain or improve academic administrative units in preventive medicine and public health, or programs that improve clinical teaching in preventive medicine and public health.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), a total of 61 preventive medicine residents were trained through support from the PMR program; of these residents, 25 completed their training during that year. Among residents who completed their training, 39% were underrepresented minorities—exceeding the program's performance target of 20% by 95%. Residents participated in clinical trainings in 100 different sites; results from the analysis of performance data showed that 2 out of every 5 sites used for clinical training were located in MUCs and/or HPSAs and served a number of populations with specific needs, such as veterans and their families, as well as children and adolescents.

Differences in targets and actuals are due to a change in the methodology for calculating the total number of trainees. Previously, the number of students completing a training program was excluded from the total number of individuals trained during any given academic year. Since program completers and/or graduates receive training during the academic year, counts have been adjusted to include these individuals and, as a result, account for the large difference in the number of residents trained between FY 2010 (45) and FY 2011 (61).

Integrative Medicine Program

The Integrative Medicine Program (IMP) program—which falls under BHPr's Public Health and Preventive Medicine program—seeks to: 1) incorporate evidence-based integrative medicine content into existing preventive medicine residency programs; 2) provide faculty development to improve clinical teaching in both preventive and evidence-based integrative medicine; and 3) facilitate delivery of related information that will be measured through competency development and assessment of the residents.

Eligible Entities: Eligible applicants for the IMP grants must be a graduate medical education program in preventive medicine at: (1) an accredited school of public health or school of medicine or osteopathic medicine; (2) an accredited public or private nonprofit hospital; and/or (3) a state, local, or tribal health department. All graduate medical education programs (residencies) must be accredited by the Accreditation Council on Graduate Medical Education (ACGME) or approved by the American Osteopathic Association (AOA).

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Preventive medicine physicians	• Residency training	• Plan and develop curricula for existing residency programs • Maintain or improve existing residency programs • Provide financial support to residency trainees • Support planning, developing operations, and/or participation residency programs • Establish, maintain, or improve academic administrative units in preventive medicine or programs that improve clinical teaching in preventive medicine

Program Accomplishments: Program is in its first year and does not yet have performance data to report.

Funding History

FY	**Amount**
FY 2010	$9,647,000
FY 2010 (PPHF)	$14,829,000
FY 2011	$9,609,000
FY 2011 (PPHF)	$20,000,000
FY 2012	$8,144,000
FY 2012 (PPHF)	$25,000,000
FY 2013	$8,243,000
FY2014	$3,226,000
FY 2014 (PPHF)	$4,776,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $8,002,000. The FY 2014 Request is $25,142,000 below the FY 2012 Enacted level. $2,191,510 of PPHF will be used to fund 6 PMR non-competing continuation grants. $2,584,490 of PPHF will be used to fund 16 PHTC non-competing continuation grants, and $3,226,000 will be used to fund the remaining 21 PHTC non-competing continuation grants. There will be no funding in FY 2014 for the PHT program.

Outcomes and Outputs Tables
The table below includes some developmental performance measures for activities supported through the Prevention and Public Health Funds. Because these activities have not yet been initiated and baselines have not been established, these measures may require revisions when they are implemented.

Measure	Year and Most Recent Result[84] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Public Health Training Center				
6.I.C.9: Number of existing public health workers who completed continuing education sessions (PPHF)	161,780 Target: 205,645 (Target Not Met)	205,645	40,445	-165,200
6.I.C.18: Number of contact hours of continuing education offered by the PHTCs[85] (PPHF) (Developmental)	513,978 (Historical Actual)	300,000	128,495	-171,505
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal	--	--	TBD	--

[84] Most recent results are for Academic Year 2011-2012, funded in FY 2011.
[85] Baseline for this measure will be in FY 2012.

Measure	Year and Most Recent Result[84] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Health Departments (PPHF)[86]				
Public Health Traineeships [87]				
Number of students supported with traineeship funds	350 Target: 501 (Target Not Met)	500	--	-500
Number of graduates supported with traineeship funds	98[88] Target: 115 (Target Not Met)	115	--	-115
Preventive Medicine Residency Training				
Number of residents participating in residencies	61[89] Target: 45 (Target Exceeded)	40	40	Maintain
Number of residents completing training	25 Target: 25 (Target Met)	20	15	-5
Number of URM residents completing training	13 Target: 9 (Target Exceeded)	9	7	-2
Percent of URM residents completing training	39% Target: 20% (Target Exceeded)	20%	20%	Maintain
6.I.C.14: Number of residents enrolled in preventive medicine programs that have incorporated evidence-based integrative medicine principles into the curriculum (including both practica and	--	TBD	TBD	--

[86] Baseline for this measure will be in FY 2013.
[87] Funded by both Prevention and Public Health Fund (PPHF) and regular appropriations.
[88] Graduates are a subset of the total number of students supported.
[89] Methodology for calculating number of trainees was updated to include new and continuing students, as well as those who completed the program during the academic year. Previous calculations erroneously did not count individuals who were students and completed their requirements during the academic year.

Measure	Year and Most Recent Result[84] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
didactic academic course work)[90]				
6.I.C.15: Number of technical assistance consultations provided by the National Coordinating Center for Integrative Medicine (NccIM)[91]	--	TBD	TBD	--

Grant Awards Table – Public Health Training Centers Program
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	37	37	37
Average Award	$628,826	$125,000	$125,000
Range of Awards	$130,000-$650,000	$100,000-$150,000	$100,000-$150,000

Grant Awards Table – Public Health Traineeships
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	46	--	--
Average Award	$47,880	--	--
Range of Awards	$2,300-$205,000	--	--

[90] Baseline for this measure will be in FY 2013.
[91] Baseline for this measure will be in FY 2013.

Grant Awards Table – Preventive Medicine Residency Program

Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	9	6	6
Average Award	$423,666	$350,000	$350,000
Range of Awards	$190,000-$783,000	$150,000-$600,000	$150,000-$600,000

Nursing Workforce Development

Advanced Nursing Education

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$63,469,000	$64,316,000	$83,469,000	+$20,000,000
FTE	4	4	4	---

Authorizing Legislation: Section 811, Public Health Service Act, Title VIII, as amended by the Affordable Care Act

FY 2014 Authorization .....Such Sums as Necessary

Allocation Method .....Formula Grant/Competitive Grant/Contract

Program Goal and Description: The Advanced Nursing Education Programs provide funding for institutions to create or expand projects that support the enhancement of advanced nursing education and practice. The Advanced Nursing Education Programs are comprised of the following:

- Advanced Nursing Education (ANE) Program and the Advanced Nursing Education Expansion (ANEE) Programs - provide funding for institutions to create or expand projects that support the enhancement of advanced nursing education and practice, including nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse administrators, public health nurses and other specialties requiring advanced education. The goal of the ANE and ANEE programs is to increase the supply of advanced practice nurses.

- Nurse Anesthetist Traineeship (NAT) Program - awards grants to accredited institutions that train nurse anesthetists in order to increase access to nurse anesthetist care for underserved populations who are underrepresented in the health care workforce. Grant funding is used for traineeships for licensed registered nurses enrolled as full-time students beyond the twelfth month of study in a master's or doctoral nurse anesthesia program. Traineeships will pay all or part of the costs of the tuition, books, fees and the reasonable living expenses of the individual during the period for which the traineeship is provided.

- The Advanced Education in Nursing Traineeship (AENT) Program - awards grants to accredited institutions to increase the number of advanced education nurses trained to practice as primary care providers or nurse midwives. Grant funding is used for traineeships that will pay all or part of the costs of tuition, books, and fees of the

program of advanced nurse education, and the reasonable living expenses of the individual during the period for which the traineeship is provided.

Need: The combined factors of an aging workforce and population growth are expected to result in increased demand for health care services, in particular primary care services. Advanced practice registered nurses (APRNs) are a critical part of the primary care workforce and will be needed in growing numbers to meet this increasing demand. Building this workforce will require support for advanced nursing education students, specifically those electing primary care practice disciplines. In addition, this program is responsive to the evolving health care needs of patients and families and to ensure that advanced nursing education programs prepare nurses with the skills to meet these needs and provide care in complex, high-tech health care systems that are moving to team-based models of care.

Advanced Nursing Education Programs

Programs	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Advanced Nursing Education	$38,469,000	$39,316,000	$38,925,000
Advanced Education Nursing Traineeship	$22,750,000	$22,750,000	$42,750,000
Nurse Anesthetist Traineeship	$2,250,000	$2,250,000	$2,250,000

Advanced Nursing Education and Advanced Nursing Education Expansion Programs

The ANE and ANEE Programs aim to support advanced education program development in schools of nursing and increase the size of advance practice nurse workforce. The purpose of the ANE program is to provide funding for programs that support the enhancement of advanced nursing education and practice. Examples include curriculum development, training in new technologies and interprofessional practice. The ANEE program has two purposes which are 1) to increase the number of students enrolled full time in accredited primary care nurse practitioner and nurse midwifery programs, and 2) to accelerate the graduation of part time students by encouraging full-time enrollment. The ANEE program provides support for students to complete their course of study by providing stipends that cover educational or other reasonable living expenses.

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nurse practitioners • Clinical nurse specialists	• Graduate (master's and doctoral)	• Provide quality primary health care in homes, ambulatory care,

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses		long-term care, acute care, and other health care settings. • Build and enhance advanced nursing education programs. • Provide financial support to advanced nursing education students.

Program Accomplishments: The Advanced Nursing Education (ANE) program funds a number of grant activities—including several traineeships and an expansion program—that aim to increase the size and quality of the advanced nursing workforce. In FY 2011 (Academic Year 2011-2012), grantees of the ANE program exceeded several of the program's performance targets regarding the overall number of nursing students reached through the program. For example, grantees trained over 7,800 students—exceeding the program's performance target of 6,255 by 25%. Among students trained, over 3,000 were minority and/or disadvantaged students—exceeding the program's performance target of 1,560.

Several factors have affected the performance of the ANE-funded grant activities over the past several fiscal years. For example, the number of Masters programs receiving ANE funds decreased in Academic Year 2010-2011 while the number of Doctor of Nursing Practice (DNP) programs increased. Students enrolled in masters programs full-time typically require two years or less to complete their degree, while students enrolled in DNP programs can take three years or more to complete their programs. This affects the number of possible graduates in a given fiscal year. Since there is an increased emphasis on establishing the DNP degree as the entry-level requirement for advanced nursing practice, the overall decrease in graduates may continue over the next several fiscal years. As a result, performance targets related to this measure for FY 2014 and beyond will be adjusted to capture this profession-specific trend.

Other factors affecting performance of ANE-funded grant activities include changes in the administration and/or focus of grant programs. For example, the AENT program previously was a formula-based program that supported nurses of all disciplines. The program has been redesigned and now places an increased emphasis on supporting nursing students who will specialize in primary care, and awards are now determined through an objective review process rather than a formula. This type of change has contributed to the large disparity between the performance targets and actual results for the AENT program.

Enrollment rates in full-time nursing programs have, to some degree, been lower than expected. For example, performance data has shown that the immediate pool of potential ANEE stipend recipients was not as large as anticipated, as ANEE stipends are for full-time students only. Although students who convert from part-time to full-time enrollment are eligible for ANEE stipends, schools have identified difficulties in recruitment and a need for adequate time to promote the program among these students. While the number of students receiving ANEE

stipends has increased in the second academic year, the lag in stipend recipients from the first academic year has affected the cumulative total of enrollees.

Advanced Education Nursing Traineeship Program

The Advanced Education Nursing Traineeship (AENT) program aims to increase the number of advanced education nurses trained to practice as primary care nurse practitioners or nurse midwives by providing traineeships to offset the costs of tuition, textbooks and reasonable living expenses.

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nurse practitioners • Clinical nurse specialists • Nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses	• Graduate (master's and doctoral)	• Provide education and training for nurses to provide quality primary health care in homes, ambulatory care, long-term care, acute care, and other health care settings. • Provide traineeships for tuition, fees, books, and reasonable living expenses

Nurse Anesthetist Traineeship Program

The NAT program aims to increase access to nurse anesthetist care for underserved populations who are underrepresented in the health care workforce. The program seeks to address the maldistribution of primary care nurse anesthetists in the United States.

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Nurse anesthetists	• Graduate programs in nurse anesthesia (master's and doctoral)	• Supports education of nurse anesthetists to provide quality health care in underserved areas, including Health Professional Shortage Areas (HPSAs)

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
		• Provide traineeships for tuition, fees, books, and reasonable living expenses

Program Accomplishments: Grantees of the AENT and the NAT programs also exceeded performance targets regarding the number of traineeships supported in FY 2011. Analysis of performance data showed that grantees of the AENT and NAT programs provided direct financial support to 11,242 nursing and nurse anesthesia students—exceeding the program's performance target of 2,910. Among students supported, over 4,300 graduated and were ready to enter the workforce as of June 2012—exceeding the program's performance target of 1,510. In addition, analysis of prior year data showed that 1,700 students who graduated from AENT and NAT programs in FY 2010 entered practice in medically underserved communities and/or health professional shortage areas—exceeding the program's performance target of 780.

Funding History

FY	Amount
FY 2010	$64,301,000
FY 2010 (PPHF)	$31,431,000
FY 2011	$64,046,000
FY 2012	$63,469,000
FY 2013	$64,316,000
FY 2014	$83,469,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with the responsibility of advising the Secretary and Congress on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $83,469,000. The FY 2014 Request is $20,000,000 above the FY 2012 Enacted level. This request supports investments to expand the production and skills of the advanced nursing education workforce needed to meet the public's growing demand for accessible quality health care services.

Building on a FY 2010 expansion initiative, the FY 2014 Request will provide increased funding to expand the pool of primary care APRNs through the AENT program. Funds allocated for the ANEE II expansion program will be reallocated to the AENT program, as both programs have a similar purpose. The consolidation of these two programs will allow for greater efficiency in targeting and funding programs that will recruit, retain and graduate primary care nurse

practitioners and nurse midwives. Along with sustained funding, the increased funding will produce an additional 1,800 primary care nurses over a five year period (FYs 2014 – 2018).

The AENT Program was restructured in FY 2012 in two ways: 1) it was converted from a formula-based to competitive grant program; and 2) traineeship support was targeted to primary care APRNs. Funds for the first year of training for nurse anesthesia students, which had been provided under the AENT program prior to FY 2012, were shifted to the NAT program. This shift in resources allows the NAT program, which continues as a formula-based program, to provide full two-year traineeship support for nurse anesthesia students.

BHPr is in the process of designing and implementing a longitudinal evaluation for the AENT program that would assist in monitoring the impact of the program (e.g., on training and post-graduation placement in primary care and underserved communities.

The scope and funding level for the ANE program will be maintained in FY 2014.

Outcomes and Outputs Tables

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**[92]	**FY 2012 Target**	**FY 2014 President's Budget**	**FY 2014 +/- FY 2012**
Advanced Nursing Education Program[93]:				
Number of students	7,825 Target: 6,255 (Target Exceeded)	6,255	6,255	Maintain
Number of minority or disadvantaged students enrolled	3,115 Target: 1,560 (Target Exceeded)	1,560	1,560	Maintain
Percent minority/disadvantaged enrollment	40% Target: 24% (Target Exceeded)	24%	24%	Maintain
Number of graduates	1,468 Target: 1,785 (Target Not Met)	1,785	1,485	-300
Traineeship Programs[94]:				

[92] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.
[93] ANE Program outputs include trainees across all specialties.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)[92]	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of students supported	12,466 Target: 2,910 (Target Exceeded)	2,910	3,775	+865
Number of graduates supported	4,608 Target: 1,510 (Target Exceeded)	1,510	2,425	+915
Number of graduates practicing in underserved areas	1,796 Target: 780 (Target exceeded)	920	1050	+130
ANEE Program:				
6.I.C.7**:** Number of Primary Care Nurse Practitioner students supported	368 Target: 300 (Target Exceeded)	300	300	Maintain
6.I.C.3.c: Number of nurse practitioners who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding[95] (cumulative)	--	260	430	+170
6.I.C.3.d: Number of nurse midwives who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding[96]	---	---	TBD	---

[94] Traineeship programs include the AENT and NAT programs.
[95] First graduating class from the ANEE program will be in FY 2012. Performance target includes nurse practitioners and nurse midwives.
[96] Baseline for this measure will be in FY 2013. Outputs are a subset of totals reported for measure 6.I.C.3.c.

Grant Awards Table – ANE

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	125	125	125
Average Award	$278,300	$278,300	$278,300
Range of Awards	$79,500-589,400	$79,500-589,400	$79,500-589,400

Grant Awards Table – AENT

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	65	65	121
Average Award	$253,000	$253,000	$330,000
Range of Awards	$165,000-$330,000	$165,000-$330,000	$220,000-$440,000

Grant Awards Table – NAT

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	82	82	82
Average Award	$25,000	$25,000	$25,000
Range of Awards	$2,800-$69,000	$2,800-$69,000	$2,800-$69,000

Grant Awards Table – ANE Expansion II

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	--	29	--
Average Award	---	$576,000	--
Range of Awards	---	$570,000-$580,000	--

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$15,819,000	$16,077,000	$15,819,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 821 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Nursing Workforce Diversity (NWD) program increases nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses, by supporting activities such as the provision of student stipends and scholarships, pre-entry preparation, advanced education preparation, and retention activities. The NWD program will increase nursing education opportunities for individuals from disadvantaged backgrounds to produce a more diverse nursing workforce. This outcome will help meet the increasing need for culturally aligned, quality health care for the nation's rapidly diversifying population and help close the gap in health disparities.

Need: A diverse health care workforce with diverse leadership is necessary to help meet the needs of a diverse minority population and reduce health disparities and inequities. A U.S. HHS Office of Minority Health report identifies 14 principles for minority health equity, including the recommendation for health care professional schools and the health care workforce to represent and reflect the diverse communities.[97] The 2008 National Sample Survey of Registered Nurses reports that only 17 percent of the nursing workforce comes from racial/ethnic minority groups. This under-representation of racial/ethnic minority nurses is fed by comparable under-representation among nursing educators. A survey of nurse educators conducted by the National League for Nursing and the Carnegie Foundation's Preparation for the Professions Program found that only 7 percent of nurse educators were minorities compared with 16 percent of all U.S. Faculty.[98] While there has been a modest increase, substantial additional efforts are needed to narrow the diversity gap between nursing and the general population. An estimated 500,000

[97] U.S. Department of Health and Human Services, Office of Minority Health, (July, 2009). Ensuring that health care reform will meet the health care needs of minority communities and eliminate health disparities, Available at: http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/ACMH_HealthCareAccessReport.pdf

[98] Kaufman, K. Headlines from the NLN - introducing the NLN/Carnegie national survey of nurse educators: compensation, workload, and teaching practice. Nursing Education Perspectives 2007;28(3):164-9.

registered nurses from racial/ethnic minority groups would be needed if the nurse population were to reflect the U.S. population as a whole.

Eligible Entities: Accredited schools of nursing, nursing centers, academic health centers, State or local governments, and other private or public entities, including faith-based and community based organizations, and tribes and tribal organizations.

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Registered Nurses (RNs) • Second degree students	• Pre-Entry Preparation - middle school students - high school students - high school graduates or equivalent - certified nursing assistants - licensed practical or vocational nurses • Diploma or Associate Degree RNs • Individuals with bachelor's degree in another discipline • RNs who matriculate into accredited bridge or degree completion program within the three-year project period. • Baccalaureate degree • Advanced nursing education and nurse faculty preparation,	• Use academic, social and financial supports to support basic preparation and educational advancement of disadvantaged and minority nurses for leadership positions within the nursing profession and the health care community. • Support pre-entry academic advising, mentoring, and enrichment activities. • Prepare diploma or associate degree RNs to become baccalaureate-prepared RNs. • Prepare practicing RNs for advanced nursing and nursing faculty roles.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), the focus of the NWD program changed to reflect a higher emphasis on students and graduates of diploma and college-level nursing programs over those at the elementary/secondary or pre-college levels. Changes in the focus of the program were made in an attempt to ultimately increase the number of nursing graduates eligible to sit for the licensing exam. As a result, FY 2011 performance targets regarding the number of program participants at the elementary/secondary and/or pre-college levels were not met and differ from outcomes observed for previous fiscal years. Nonetheless, analysis of performance data for FY 2011 showed that grantees of the NWD program provided scholarships to 1,270 students—exceeding the program's performance target of 735 by 72%. Performance measures and related targets for FY 2014 and beyond will be adjusted to reflect changes in the focus of the NWD program so as to better capture appropriate outputs and outcomes.

Funding History

FY	Amount
FY 2010	$16,073,000
FY 2011	$16,009,000
FY 2012	$15,819,000
FY 2013	$16,077,000
FY 2014	$15,819,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with advising the Congress and Secretary on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $15,819,000. The FY 2014 Request is the same as the FY 2012 Enacted level. This request will continue to fund the education of pre-nursing and nursing students to become registered nurses and the preparation of participants for entry into a professional nursing program through pre-entry preparation, retention and stipend/scholarship program activities. The reauthorization of the Nursing Workforce Diversity program under the Affordable Care Act added the authority to support advanced nursing education. The persistent under-representation of racial/ethnic minority groups and level programmatic funding prompts an initiative targeting efforts to diversify the ranks of nursing faculty.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[99]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Disadvantaged Students/Participants				
Percent of underrepresented minority students	68% Target: 70% (Target Not Met)	70%	70%	Maintain
Percent of white disadvantaged students/participants	39% Target: 27% (Target Exceeded)	30%	35%	+5 percentage points

[99] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Measure	Year and Most Recent Result[99]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Level of Students/Participants				
Number of nursing program students	2,974 Target: 3,350 (Target Not Met)	3,350	2,500	-850
Number of post high school, college, and pre-entry nursing students	401 Target: 1,300 (Target Not Met)	1,300	300	-1,000
Number of K-12 students/participants	1,600 Target: 5,900 (Target Not Met)	5,900	1,500	-4,500
Number of nursing students graduating from nursing programs	694 Target: 950 (Target Not Met)	950	750	-200
Student Financial Support				
Number of nursing students expected to receive scholarships	1,270[100] Target: 735 (Target Exceeded)	735	1,000	+265

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	45	45	45
Average Award	$316,000	$316,000	$316,000
Range of Awards	$134,600-$528,000	$134,600-$528,000	$134,600-$528,000

[100] Methodology for calculating number of students supported was updated to include new and continuing students, as well as those who completed the program during the academic year. Previous calculations erroneously did not count individuals who were received support and completed their requirements during the academic year.

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$39,638,000	$39,820,000	$39,638,000	---
FTE	4	4	4	---

Authorizing Legislation: Section 831 and Section 831A of the Public Health Service Act, as amended by the Affordable Care Act

FY 2014 Authorization Section 831 .....Such Sums as Necessary

FY 2014 Authorization Section 831A…….....Expired

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Nurse Education, Practice, Quality and Retention (NEPQR) Program is broad in scope and supports initiatives to expand the nursing pipeline, promote career mobility, enhance nursing practice, increase access to care and interprofessional clinical training and practice, and support retention. This program seeks to build and expand nursing educational programs to increase the number of qualified nurses in the health care workforce while addressing the national nurse shortage.

Need: A growing and aging population continues to increase the demand for nursing services. At the same time the nursing workforce is steadily aging and projected retirements from the workforce are expected to significantly shrink the supply of qualified personnel. The NEPQR program seeks to address this gap by increasing our nation's nursing workforce capacity and addressing the inequitable distribution of the nursing workforce across the United States. Grant support is provided for academic, service and continuing education projects designed to enhance nursing education, improve the quality of patient care, increase nurse retention and strengthen the nursing workforce.

Eligible Entities: Accredited schools of nursing, health care facilities, and partnerships of a nursing school and health care facility.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Registered nurses • Certified nursing assistants • Home health aides	• Baccalaureate education • Advanced nursing education • Licensed practical nurses	• Expand enrollment in baccalaureate nursing programs. • Provide education in new technologies including distance

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Licensed practical nurses • Licensed vocational nurses	• Certified nursing assistants • Home health aides	learning methodologies. • Develop internships and residency programs. • Develop career ladder programs to promote career mobility in nursing. • Develop cultural competencies. • Offer programs to promote nurse retention. • Skill development in care enhancements congruent with emerging health care systems. • Increase access to care for underserved and high-risk populations and interprofessional clinical training and practice for basic and advanced practice nurses.

Program Accomplishments: The NEPQR program has a variety of legislative goals and purposes that ultimately aim to increase the size and quality of the nursing workforce. A number of grant activities have been funded to support several of the legislative purposes such as expanding the size of academic programs that are able to confer a baccalaureate degree of science in nursing (BSN); recruiting and training individuals as qualified personal and home care aides in occupational shortage and/or high demand areas; training qualified nursing assistants and home health aides to meet the growing healthcare needs of the aging population; and/or supporting nurse managed health clinics that serve as primary care access points in areas where primary care providers are in short supply.

For grantees funded to support expansion of BSN academic programs, performance data showed that a total of 5,127 BSN students supported during FY 2011—exceeding the program's performance target of 4,860 by 5%. The total number of grants focusing on expanding BSN academic programs during FY 2011 was 14. Since the NEPQR program has a variety of legislative purposes and goals, recent funding opportunities have been specific to other purposes of the program. As a result, the program was unable to meet its target of funding 22 grantees to focus on expansion. Performance targets for FY 2014 and beyond will be adjusted to take into account the current and expected number of grants that will be funded to focus on expansion, as well as other purposes of the NEPQR program.

Grantees funded to support the personal and home health aide purpose of the NEPQR program trained a total of 1,366 students during FY 2011. Grantees supporting the nursing assistant and home health aide purpose of the NEPQR program supported a total of 1,810 students[101].

[101] Includes students who received direct financial support (e.g., stipends, tuition support) as well as students enrolled in or trained through the academic program supported by the grant.

Collectively, grantees funded under these purposes had a total of over 1,900 program completers—exceeding the performance target of 1,723 by 10%.

Although performance measures and targets are specific to the expansion purpose of the NEPQR program, performance data were also collected from grantees supporting several other legislative purposes of the program. For example, grantees funded to support the nurse-managed health clinic purpose of the NEPQR program supported a total of 2,417 students; of these, 1,121 graduated and/or completed their program of study. Data provided on the populations served by NMHCs showed that clinics are serving a variety of specialized populations (e.g., veterans and/or families of active military) and continue to partner with Federally Qualified Health Centers, Area Health Education Centers, and/or rural and community-based clinics to provide training to their students.

Funding History

FY	Amount
FY 2010	$39,811,000
FY 2011	$39,653,000
FY 2012	$39,638,000
FY 2013	$39, 820,000
FY 2014	$39,638,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with advising the Secretary and Congress on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $39,638,000. The FY 2014 Request is the same as the FY 2012 Enacted level. This request will fund projects to increase the educational opportunities, clinical practice skills, and utilization of the nursing workforce to enhance the quality of patient care. Projects to develop and disseminate collaborative practice models that incorporate the full range of health care workers in team-based care are of particular interest. BHPr is funding a National Center for Interprofessional Practice plus Education (National Center) to provide infrastructure for leadership, expertise, and support to enhance the coordination and capacity building interprofessional practice and education among health professions across the U.S. and particularly in medically underserved areas. A multi-focal (process and outcome) program evaluation will assess the effectiveness of the Center's objectives, program activities and overall performance.

Outcomes and Outputs Tables

The NEPQR program has several purposes and solicits applications addressing any of its education, practice and retention purposes, one of which is accelerated BSN education projects.

The purposes of the NEPQR are broad and flexible, allowing the program to address the emerging needs in nursing workforce development to advance education and practice priorities. As the program adapts to these emerging needs and priorities in the future, new outcome measures will be added as appropriate.

Measure	Year and Most Recent Result[102]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of expanded BSN education projects	14 Target: 22 (Target Not Met)	22	22	Maintain
Number of BSN student participants	5,127[103] Target: 4,860 (Target Exceeded)	4,860	4,860	Maintain
6.I.C.6: Number of Personal Care and Home Health Aides completing training program	1,986 Target: 1,723 (Target Exceeded)	1,723	1,723	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	105	105	105
Average Award	$296,000	$296,000	$296,000
Range of Awards	$42,000-$750,000	$48,000-$800,000	$48,000-$800,000

[102] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

[103] Methodology for calculating number of trainees was updated to include new and continuing students, as well as those who completed the program during the academic year. Previous calculations erroneously did not count individuals who were students and completed their requirements during the academic year.

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$24,553,000	$24,953,000	$24,553,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 846A of the Public Health Act, as amended by the Affordable Care Act

FY 2014 Authorization .....Such Sums as Necessary

Allocation Method .....Formula Grant

Program Goal and Description: The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund at participating schools of nursing to assist nurses in completing their graduate education to become qualified nurse faculty. The NFLP seeks to increase the number and diversity of qualified nursing faculty. Eligible schools receiving awards under the NFLP are required to contribute to the loan fund no less than one-ninth of the award amount. Following graduation from the nursing program, the nursing school will cancel up to 85 percent of the loan principal and interest in exchange for the loan recipient's full-time nursing faculty service at a school of nursing, with a designated percentage cancelled each year for up to four years. The NFLP loans are repayable and/or cancelled over a ten-year repayment period.

Need: An insufficient number of qualified nursing faculty continues to be the primary barrier to accepting all qualified students at nursing colleges and universities. The current nurse faculty vacancy rate is particularly acute for doctorally-prepared faculty. Between 200-300 doctorally prepared faculty have been eligible for retirement annually over the past decade, and between 200-280 mastered-prepared faculty will be eligible to retire over the next five years.[104] Equally pressing is lack of diversity in the nursing faculty ranks. A survey of nurse educators conducted by the National League for Nursing and the Carnegie Foundation's Preparation for the Professions Program found that only 7% of nurse educators were minorities compared with 16% of all U.S. faculty.[105] The lack of faculty diversity limits nursing schools' ability to deliver culturally-appropriate health professions education needed to address the needs of the nation's rapidly diversifying population and close the gap in health disparities. Moreover, faculty diversity is an essential ingredient in the efforts to diversify the nursing education pipeline and workforce overall.

[104] American Association of Colleges of Nursing (http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage). Nurse Faculty Shortage Fact Sheet (updated April 14, 2011).
[105] Kaufman, K. Headlines from the NLN - introducing the NLN/Carnegie national survey of nurse educators: compensation, workload, and teaching practice. Nursing Education Perspectives 2007;28(3):164-9.

Eligible Entity: Accredited schools of nursing who offer advanced nursing education degree program(s) that will prepare graduate students for roles in education.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nursing	• Graduate (master's and doctoral)	• **Loan Fund:** - Provides funding to nursing schools to establish and operate revolving loan fund. - Provide low interest rate loans to nursing students. - Loans may be used to pay costs of tuition, fees, books, laboratory expenses, and other education expenses. - Requires institutional match of at least 1/9 of the Federal contribution to loan fund. - Students are limited to five years of loan support. • **Loan Cancellation Provision:** - Provide loan cancellation upon completion of service with 85 percent cancellation after 4 years of service.

Program Accomplishments: In FY 2011 (Academic Year 2011-2012), NFLP grantees provided loans to a total of 2,246 students pursuing faculty preparation at the masters and doctoral level—exceeding the program's performance target of 1,510 by 49%. Analysis of performance data showed that, of the students supported in FY 2011, over 400 graduated at the end of academic year—exceeding the performance target of 275 by 45%.

The number of schools receiving NFLP grant awards in FY 2011 was 112. While the performance target of 114 was not met, it is important to clarify that the number of schools receiving a new NFLP award does not equate to the number of schools providing NFLP loans to graduate-level nursing students. In order to receive a new NFLP award, schools must meet certain criteria with regard to available fund balances. However, even schools that do not receive new awards may continue making loans with the accounts they have already established. Therefore, although 112 schools received an NFLP award, over 160 schools provided NFLP loans to nursing students in Academic Year 2011-2012.

Funding History

FY	Amount
FY 2010	$24,947,000
FY 2011	$24,848,000
FY 2012	$24,553,000
FY 2013	$24,953,000
FY 2014	$24,553,000

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with advising Congress and the Secretary on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $24,553,000, which is the same as the FY 2012 Enacted level. Of this total request, $20,553,000 will support schools of nursing in establishing and operating loan funds for the NFLP. The number of grantee schools is not anticipated to increase as many of the schools offering faculty preparation are already funded, and each has additional unmet need. The number of schools receiving NFLP awards in any year may be lower than the total number of schools providing NFLP funds to students in that year. Some schools may have sufficient funds in their loan account from the prior year so they do not require additional funds to continue to make loans to students. The remaining $4,000,000 will be used to support an effort to increase minority faculty in nursing. Ongoing support for faculty production is critical to building the pipeline needed to assure the full capacity of the nation's future nursing workforce. Targeting a portion of those funds for minority faculty preparation is fundamental to achieving that goal.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[106] / Target for Recent Result / (Summary of Result)	FY 2013 President's Budget	FY 2014 Request	FY 2014 Request +/- FY 2013 PB
Number of schools receiving NFLP awards	112[107] Target: 114 (Target Not Met)	114	114	Maintain

[106] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

[107] An additional 50 schools had sufficient funds in their loan fund from previous NFLP awards and did not request funds this year. A total of 164 schools made NFLP awards to students.

Measure	Year and Most Recent Result[106] / Target for Recent Result / (Summary of Result)	FY 2013 President's Budget	FY 2014 Request	FY 2014 Request +/- FY 2013 PB
Number of students supported	2,246[108] Target: 1,510 (Exceeded)	1,510	1,510	Maintain
Number of graduates	408 Target: 275 (Target Exceeded)	275	275	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	114	114	114
Average Award	$205,970	$205,970	$205,970
Range of Awards	$1,000-$1,790,000	$1,000-$1,790,000	$1,000-$1,790,000

[108] These students were enrolled in programs from among all 164 schools that made NFLP awards this year.

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$4,485,000	$4,558,000	$4,485,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 865 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act

FY 2014 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: This program provides support to train and educate individuals who provide geriatric care for the elderly.

Need: More than 65 million people, 29 percent of the adult U.S. population, provide care for a chronically ill, disabled or an aged family member or friend during any given year and spend an average of 20 hours per week providing care for their loved one.[109] In addition, the Institute of Medicine[110] reported that direct-care workers, also referred to as paraprofessionals, are the primary providers of paid hands-on care, supervision, and emotional support for older adults in the U.S., primarily in nursing homes, assisted living facilities, and home and community-based settings. Projected employment for home health aides and personal and home care aides in 2020 will reach 3,191,900. This represents an increase of approximately 70 percent in the growth of jobs available in these occupations between 2010 and 2020 and makes them among the fastest growing jobs in the country[111].

Eligible Entities: Schools of nursing, health care facilities, programs leading to certification as a nursing assistant, and partnerships of such a school and facility l or program and facility.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:

[109] National Alliance for Caregiving in collaboration with AARP (2009). Caregiving in the United States 2009. www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf

[110] Institute of Medicine (2008). Retooling for an Aging America: Building the Health Care Workforce. National Academies Press, Washington, DC.

[111] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Home Health and Personal Care Aides, on the Internet at http://www.bls.gov/ooh/healthcare/home-health-and-personal-care-aides.htm (visited *May 22, 2012*).

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• All health professions • Direct service workers • Individuals	• Certificate • Diploma • Undergraduate • Graduate • Post-graduate • Individuals with no professional education	• Provide training to individuals who will provide geriatric care for the elderly. • Develop and disseminate curricula relating to treatment of health problems of elderly individuals. • Train faculty in geriatrics. • Provide continuing education to individuals who provide geriatric care. • Establish traineeships for individuals preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

Program Accomplishments: In Academic Year 2011-2012, grantees of the Comprehensive Geriatric Education Program (CGEP) provided an array of services; among these, the majority of the 18 CGEP grantees[112] focused on providing continuing education to individuals who provide geriatric care (39%) and developing and disseminating curricula relating to the treatment of health problems of elderly adults (31%). Through continuing education activities, grantees of the CGEP program reached over 8,200 trainees and delivered over 1,700 hours of instruction. Results from the analysis of performance data showed that CE offerings primary focused on topics such as geriatric education for direct care providers (30%); palliative and end-of-life care (15%); and health care and older adults (13%). Data provided on partnerships made for the purposes of delivering CE offerings showed that CGEP grantees are commonly partnering with Area Health Education Centers (22%); Other Academic Departments (19%); as well as other grantees of the CGEP program (15%).

[112]Based on partial data reported by 18 of the 27 CGEP grantees for Academic year 2011-2012.

Funding History

FY	Amount
FY 2010	$4,557,000
FY 2011	$4,539,000
FY 2012	$4,485,000
FY 2013	$4,558,000
FY 2014	$4,485,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $4,485,000. The FY 2014 Request is the same as the FY 2012 Enacted level. This request will fund 18 Comprehensive Geriatric Education Program grantees. The Affordable Care Act expanded the use of funds for the Comprehensive Geriatric Education Program to include the establishment of traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population. In FY 2012, the average award increased from $127,000 to $232,565 to fund a total of 56 trainees who are preparing for advanced practice nursing careers in 12 of 18 funded projects. The increase in the amount of the average award resulted in a decrease in the number of grantees from 27 (funded in FY 2011) to 18.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[113]/Target for Recent Result (Summary of Result)	FY 2014 President's Budget	FY 2014 +/- FY 2012
Number of CGEP Grantees	18 Target: 16 (Target Exceeded)	18	Maintain

[113] Most recent result is for Academic Year 2012-2013 and funded in FY 2012.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	18	18	18
Average Award	$232,565	$232,565	$232,565
Range of Awards	$134,673-$270,000	$134,673-$270,000	$134,673-$270,000

Children's Hospitals Graduate Medical Education Payment Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
BA	$265,171,000	$269,488,000	$88,000,000	-$177,171,000
FTE	23	23	18	-5

Authorizing Legislation: Section 340E of the Public Health Service Act; Public Law 109-307

FY 2014 Authorization ..... Expired

Allocation Method ..... Formula Based Payment

Program Goal and Description: The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals. CHGME helps eligible hospitals maintain GME programs to provide graduate training for physicians to provide quality care to children, and enhance their ability to care for low-income patients. It supports the training of residents and fellows and enhances the supply of primary care and pediatric medical and surgical subspecialties.

Need: Adequate residency training in pediatric care is important for residents who pursue a variety of specialties. Compared with other teaching hospitals, freestanding children's hospitals receive little to no GME funding from Medicare because children's hospitals have such a low Medicare caseload. The CHGME Payment Program addresses this disparity in Medicare GME funding between freestanding children's hospitals (which are often safety net hospitals) and other teaching hospitals.

Eligible Entities: Freestanding children's teaching hospitals

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Pediatric • Pediatric medical subspecialties • Pediatric surgical subspecialties • Adult primary care • Adult Medical subspecialties • Adult surgical	• Graduate medical education	• Operate accredited graduate medical education programs for residents and fellows • Submit an annual report on the status and expansion of GME in their institutions.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
subspecialties • Dentistry		

Program Accomplishments: In FY 2012, 55 children's hospitals received CHGME funding. Based on the most recent year for which performance information was reported, these children's hospitals reported being responsible for the training of 6,185 full-time equivalent (FTE) residents on and off site.[114] Approximately 43 percent of the FTEs were pediatric residents, 32 percent were pediatric subspecialty residents, and 26 percent non-pediatric residents such as family children in their respective areas of expertise.

Funding History

FY	Amount
FY 2010	$316,824,000
FY 2011	$268,356,000
FY 2012	$265,171,000
FY 2013	$269,488,000
FY 2014	$88,000,000

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2014 Budget Request is $88,000,000. The FY 2014 Request is $177,171,000 below the FY 2012 Enacted level. This request will fund direct medical expenses (DME) for graduate medical education for residents currently in the program. There are two types of GME funding, direct and indirect. Direct medical education spending includes expenditures related to stipends and fringe benefits for residents; salaries and fringe benefits of supervising faculty; cost associated with providing the GME training program; and, allocated institutional overhead costs. Indirect medical education (IME) spending includes expenditures associated with the reduced productivity of the hospital staff because they are helping train residents, and the processing of additional diagnostic tests that residents may order during their clinical experience. The proposed budget will continue to support the training of residents in freestanding children's hospitals and will not support the IME costs. In a time of limited federal resources, the FY 2014 Budget Request does not request funding for these costs.

Outcomes and Outputs Tables

[114] Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period.

Measure	Year and Most Recent Result[115]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
7.I.A.1: Maintain the number of FTE residents in training in eligible children's teaching hospitals	6,185 Target: 5,900 (Target Exceeded)	5,900	6,000	+100
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	100% Target: 100% (Target Met)	100%	100%	Maintain
7.E: Percent of payments made on time	100% Target: 100% (Target Met)	100%	100%	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	55	54	54
Average Award	$4,523,065	$4,990,519	$1,600,000
Range of Awards	$23,000-$16,708,000	$37,064 - $20,515,304	$8,500 - $6,161,000

[115] Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period. The most recent result is for Academic Year 2011-2012 and funded in FY 2011.

National Practitioner Data Bank

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$28,016,000	$28,016,000	$28,016,000	---
FTE	40	46	46	+6

Authorizing Legislation: Section IV, P.L. 99-660; Healthcare Quality Improvement Act of 1986, as amended by P.L. 100-177; Section 1921 of the Social Security Act as amended by Section 5(b), Medicare and Medicaid Patient Protection Act of 1987 (P.L. 100-93), and Omnibus Budget Reconciliation Act of 1990 (P.L. 100-508); Subtitle C of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), establishes Section 1128E of the Social Security Act; and Section 6403 of the Affordable Care Act of 2010.

FY 2014 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Goal and Description: The National Practitioner Data Bank (NPDB) serves as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. The NPDB aims to alert users to the value of completing a thorough review of past actions of health care practitioners, providers and suppliers while encouraging professional peer review, assist in the prevention and reduction of health care fraud and abuse and promote quality health care. Used in conjunction with information from other sources, the NPDB assists in promoting quality health care, and deterring fraud and abuse in the health care delivery system.

Need: The Nation must have ongoing protections for the delivery of safe health care. Therefore, health care practitioners must be monitored and restrictions must be imposed on incompetent health care practitioners ensuring they are unable to move from state to state, without discovery of previous substandard performance or unprofessional conduct.

Consolidation: The ACA requires that the Healthcare Integrity and Protection Data Bank (HIPDB) be merged into the NPDB, thus ending the duplication of effort and cost between the two Data Banks. This will effectively move HIPDB revenue and associated costs into the NPDB. The users that currently query both Data Banks will receive the same information with one query, thereby reducing their cost by half. Public comments were received on the Notice of Proposed Rulemaking and final regulations are under review. The merger of the two Data Banks is scheduled to occur after the publication of final regulations.

Program Accomplishments:

- Implemented process efficiencies and an internal web based application to perform daily work resulting in an increase in completed dispute cases.
- Our most recent full review of 960 state regulated professions has shown a fully compliant rate of 96%.
- Expanded statistical information on the NPDB website including an interactive U.S. map and a web-based tool that allows users to perform basic research by creating customized reports.
- DPDB initiated a number of system enhancements, which combined with compliance activities continuously and substantially improve the quality of Data Bank data. These include providing those who report into the data banks the option to send a report electronically rather than through the U.S.P.S. to the state licensing board and consolidating multiple reports related to a single incident are consolidated into one document.

IT Investments: The NPDB is a web based electronic reporting and querying system that has been operational since 1999. Reports and queries can be submitted interactively using the web-based Integrated Query and Reporting Services (IQRS) over the internet or via electronic file transfer using a transmission protocol and format specified by the Data Bank. Credit card and Electronic Funds Transfer (EFTs) transactions are securely processed using the U.S. Department of Treasury's Pay.gov service. The IT investment supports the Data Bank's strategic mission by providing information to the users expeditiously.

Funding History

The table below shows the user fees (revenue) collected during the last five years:

FY	Amount
FY 2010	$27,717,315
FY 2011	$26,976,194
FY 2012	$29,242,584
FY 2013	$28,016,000
FY 2014	$28,016,000

Budget Request

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds. Instead, the NPDB is financed by the collection of user fees. Annual Appropriations Act language since FY 1993 requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriation for operating the NPDB. It is anticipated that with the implementation of Section 6403 of the Affordable Care Act, the HIPDB will be terminated and merged into the NPDB in FY 2013. User fees are established at a level to cover all program costs to allow the Data Bank to meet annual and long term program performance goals. Fees are established based on query volume to result in adequate, but not

excessive, revenues to pay all program costs to meet program performance goals. The NPDB estimate for FY 2014 is 6,280,000 queries, resulting in projected user fee collections of $28,016,000.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[116] /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day.	1,401,701 Target: 990,000 (Target Exceeded)	990,000 Enrolled practitioners	1,149,000	+159,000
8.III.B.6: Increase annually the number of reports disclosed to health care organizations through Continuous Query.	13,731 (Historical Actual)	--	16,100	--

[116] The most recent result is for FY 2012.

Maternal and Child Health Tab

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$638,646,000	$649,046,000	$638,646,000	---
FTE	29	29	29	---

Authorizing Legislation - Title V of the Social Security Act.

FY 2014 Authorization $850,000,000

Allocation Methods:

- Direct Federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The mission of the Maternal and Child Health (MCH) Block Grant Program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers, children, and their families. These legislated responsibilities reduce health disparities, improve access to health care, and improve the quality of health care. Specifically, the Program seeks to: (1) assure access to quality care, especially for those with low-incomes or limited availability of care; (2) reduce infant mortality; (3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women); (4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; (5) provide and ensure access to preventive and primary care services for low income children as well as rehabilitative services for children with special health needs; (6) implement family-centered, community-based, systems of coordinated care for children with special health care needs (CSHCN); and (7) provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

Section 502 of the Social Security Act states that of the amounts appropriated, up to $600,000,000, 85 percent is for allocation to the States, and 15 percent is for Special Projects of Regional and National Significance (SPRANS) activities. Any amount appropriated in excess of $600,000,000 is distributed as follows: 12.75 percent is for Community Integrated Service Systems (CISS) activities; of the remaining amount, 85 percent is for allocation to the States, and

15 percent is for SPRANS activities. Appropriations language waives this provision and provides a stated amount for SPRANS and CISS.

The MCH Block Grant is at its core a public health program that reaches across economic lines to improve the health of all mothers and children. Created as a partnership with State MCH programs and with broad State discretion, State Title V programs use appropriated formula grant funds for: capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening and genetic services, lead poisoning and injury prevention, additional support services for children with special health care needs, and promotion of health and safety in child care settings.

Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to provide categorical direct care such as prenatal care or services for children with special health care needs. The Title V program is the payer of last resort.

Table 1. Maternal and Child Health Block Grant Activities ($ in thousands)

MCH Activities	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Request	FY 2014+/- FY 2012
State Block Grant Awards[117]	$549,729	$558,680	$549,729	---
SPRANS	78,641	79,922	78,641	---
CISS	10,276	10,444	10,276	---
Total	$638,646	$649,046	$638,646	---

Additional activities that support the improved health care of mothers and children are SPRANS and CISS. SPRANS funds support projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening and follow-up, sickle cell disease, hemophilia, and maternal and child health improvement. SPRANS projects must:

- Support national needs and priorities or emerging issues;
- Have regional or national significance; and
- Demonstrate ways to improve State systems of care for mothers and children.

[117] Through the MCH Block Grant, HRSA distributes funding to the States, provides oversight by requiring States to report progress annually on key MCH performance/outcome measures and indicators, and offers technical assistance to States to improve performance. Each State is responsible for determining its MCH priorities, based on the findings of a comprehensive Needs Assessment every five years, targeting funds to address the identified priorities and reporting annually on its progress. The MCH Block Grant emphasizes accountability in ensuring that States meet the legislative and programmatic requirements while providing appropriate flexibility for each State to address the unique needs of its MCH population.

CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children using one or more of six specified strategies:

- Provide maternal and infant home health visiting, health education, and related support services for pregnant women and infants up to one year old;
- Increase participation of obstetricians and pediatricians under Titles V and XIX;
- Integrate MCH service delivery systems;
- Operate MCH centers under the direction of not-for-profit hospitals;
- Increase MCH projects in rural areas; and
- Provide outpatient and community-based services for children with special healthcare needs.

Table 2. Maternal and Child Health Block Grant SPRANS Set-Aside Grants ($ in thousands)

MCH SPRANS Set-Aside Programs	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Request	FY 2014+/- FY 2012
SPRANS	$67,786	$68,890	$67,786	---
SPRANS - Oral Health	3,775	3,837	3,775	---
SPRANS – Epilepsy	3,642	3,701	3,642	---
SPRANS - Sickle Cell	2,961	3,009	2,961	---
SPRANS - Fetal Alcohol	477	485	477	---
Total SPRANS	78,641	79,922	78,641	---
CISS	$10,276	$10,444	$10,276	---

The MCH Block Grant Program provides support to all 59 States and jurisdictions. Consistent with other HRSA programs, the MCH Block Grant addresses three overarching goals: 1) improving access to quality health care and services; 2) improving health equity; and 3) building healthy communities.

Funds are allotted to States based on a legislated formula which provides the amount allotted to each State in FY 1983, and when the amount available exceeds that level, the excess is distributed based on the States' proportion of children in poverty. Historically, the State Title V MCH Block Grant allocations were calculated based on the child poverty data reported in the U.S. Census Bureau's decennial census. The American Community Survey (ACS) replaced the decennial census long form as the source for annual State-specific child poverty statistics. Beginning in FY 2013, data from the ACS will be used as the reference data for calculating the annual State Title V MCH Block Grant formula allocations. The State table reflects the use of 3-year ACS child poverty data, based on the 2010 3-year estimates released in September 2011, for the FY 2013 allocations and the 2011 3-year estimates released in September 2012 for the FY 2014 allocations.

Accomplishments

By working to improve access to quality health care and services, the Program has been able to exceed the targets for both the number of children served by the States under Title V (37.4 million in FY 2011) and the number of children receiving Title V services who have Medicaid and Child Health Insurance Program (CHIP) coverage (14.8 million in FY 2011). In FY 2011, the MCH Block Grant Program served the largest number of children since data collection began in the Title V Information System in the 1990's. After years of steady increases, 0.9 million fewer children were served by Title V who had Medicaid and CHIP coverage in FY 2010 than in FY 2009. This decrease was partially reversed in FY 2011. Despite the decrease that occurred in FY 2010, the number served in FY 2011 (14.8 million children) is a significant increase over the FY 2002 baseline of 5.9 million. Increased coverage under Medicaid and CHIP for children receiving Title V services better assures access, availability, and continuity of care to a wide range of preventive and acute care services. Exceeding the targets is significant as these increases occurred in a period of severe financial constraints at the State and local levels.

Health Equity

Title V programs work to improve health equity and eliminate disparities in health outcomes through the removal of economic, social, and cultural barriers to receiving comprehensive, timely, and appropriate healthcare. The ratio of the Black infant mortality rate to the White infant mortality rate decreased from 2.48:1 to 2.24:1 from FY 2002 to FY 2010. Preliminary data indicate that the ratio did not change from FY 2010 to FY 2011(National Vital Statistics Reports).

The Title V Program plays an important role in the delivery of appropriate and effective care for high-risk pregnant women and infants. Efforts to reduce the overall infant mortality rate continue, with the rate having decreased from 9.2 per 1,000 live births in 1990 to 6.2 per 1,000 live births in 2010. Based on preliminary data, the infant mortality rate decreased to an all-time low of 6.1 infant deaths per 1,000 births in 2011 (National Vital Statistics Report). With the exception of 2002 and 2005, the infant mortality rate either statistically remained the same or it decreased significantly for each successive year between 1958 through 2011. An increase in the infant mortality rate to 7.0 per 1,000 in 2002 reversed, temporarily, a long term downward trend. Analysis of the 2002 increase concluded that factors contributing to the increase included the higher risk profile of multiple births and an increase in the number of very small infants (less than 750 grams).

HRSA has identified infant mortality as a priority issue and is working collaboratively with the Association of State and Territorial Health Officials (ASTHO), the Association of Maternal and Child Health Programs (AMCHP), CityMatCH and the March of Dimes (MOD) to support a Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. The CoIIN was launched in the U.S. Department of Health and Human Services' (HHS) Region IV and Region VI States in FY 2012 and will be expanded to other HHS Regions in FY 2013 and FY 2014. Ultimately, this effort will inform and advance the national strategy to address infant mortality that was announced by Secretary Kathleen Sebelius at the Child Survival Call to Action in June 2012.

Opportunities to Reduce Low Birth Weight

The Maternal and Child Health Bureau (MCHB) continues to explore and promote evidence-based practices to reduce the incidence and better understand the causes of low birth weight. Nationally, the number of low birth weight infants (less than 2500 grams) has been steadily increasing. From 2002 to 2006, the rate of low birth weight infants increased from a baseline of 7.8 percent to 8.3 percent. The low birth weight rate improved slightly in 2007 to 8.2 percent and remained unchanged in 2008 and 2009 (National Vital Statistics Report). Based on preliminary data, the rate of low birth weight decreased slightly to 8.1 percent in 2011.

Increases in the number of low birth weight infants have been influenced by: 1) the rise in the multiple birth rate; 2) greater use of obstetric interventions; 3) increases in maternal age at childbearing; and 4) increased infertility therapies. The delivery of very low birth weight infants (i.e. babies born weighing less than 1500 grams) at facilities with specialized equipment and personnel significantly contributes to reducing the risk of mortality. Following a decline from 75.2 percent to 71.7 percent between FY 2002 and FY 2004, the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased annually to a high of 77.3 percent in FY 2009. In FY 2010, the percent of very low birth weight infants delivered in risk-appropriate care facilities decreased to 74.5 percent.

The Bureau will work with the States to better understand the reasons for this decrease. As one of the Strategy teams participating in the Region IV and Region VI CoIIN initiative, national experts are working together to identify strategies for increasing appropriate maternal and neonatal care in 13 southern States. The Perinatal Regionalization Team, which consists of State Health Officers, Medicaid Directors, physician organizations, MCH Directors and community leaders, is engaged in a 12 – 18 month collaborative effort to develop and implement strategies for rapid, but sustainable, improvement.

Establishment of a comprehensive prenatal and perinatal care system helps to assure that very low birth weight infants are delivered in risk-appropriate care facilities. The Program partnered with CDC and AMCHP in preparing an article, published in the December 22, 2010 issue of the Maternal and Child Health Journal, which examined State measures of risk-appropriate care for very low birth weight infants and identified potential areas for improvement. State regionalization models and measures of risk-appropriate care were found to vary greatly. Mechanisms identified for better measurement of risk-appropriate care included regulation of regionalization programs, data surveillance, review of adverse events, and consideration of geography and demographics. Specific State actions included antenatal or neonatal transfer arrangements, telemedicine networks, acquisition of funding, provision of financial incentives, and patient education.

A 2009 study conducted by the Cecil G. Sheps Center and supported by the MCHB examined the trends in the rate of very low birth weight deliveries in an appropriate hospital and explored reasons that States give for change in this marker. States report that systems exist for coordinating care among multiple providers, but the extent to which regionalized perinatal care systems are regulated and prescribed varies considerably. States are examining where very low

birth weight births occur and why some do not occur in facilities for high-risk deliveries. Understanding if health care systems factors have played a role in a poor outcome and identifying which factors could potentially be modified would be an important contribution to improving this indicator. Surveillance of very low birth weight births is necessary for the quality improvement initiatives that are frequently cited by States as processes by which they hope to improve neonatal health and health care.

Prenatal Care for Pregnant Women and their Infants

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their infants. Data on the timing of prenatal care are derived from the 1989 and the 2003 Revisions of the U.S. Standard Certificate of Live Birth. Due to substantive changes in how information was reported on the timing of prenatal care in the 2003 Certificate, the two formats are not directly comparable. Prenatal care data based on the revised certificate show a less favorable picture of prenatal care utilization in the U.S. than do the data from the unrevised certificate. However, most of the difference can be attributed to changes in reporting rather than changes in prenatal care utilization.

Based on the 27 States for which 2008 revised prenatal care data were available (which represented 65% of all 2008 births), almost three-fourths (71%) of women reportedly began care within the first 3 months of pregnancy. For the 22 States that reported Revised Birth Certificate data in both 2007 and 2008, the percentage of women who received first trimester care remained essentially unchanged. Early initiation into prenatal care was less common among American Indian/Alaskan Native (53%), Black (60%) and Hispanic (65%) women compared with White (77%) and Asian (78%) women. Given the increasing prevalence of diabetes, obesity and pregnancy-induced hypertension during pregnancy, there is a need for such risk factors to be monitored and for timely and appropriate prenatal care to be provided.

Building State MCH Data Capacity

The MCHB has worked with the State MCH programs to build a data capacity that supports the performance elements in the Title V MCH Block Grant. Efforts have centered on the development of client-based data systems that more accurately capture the direct, enabling and population-based services provided, as required. Previously reported data on the number of children served by Title V and the number of children served who have Medicaid and CHIP coverage were often based on the direct services provided. In addition, increases in the number of children served by Title V who have Medicaid and CHIP coverage reflect the ongoing efforts of the States to do outreach to eligible populations and to increase participation in these programs. The MCHB regularly provides technical support to the States around the priorities identified in their comprehensive five-year needs assessments and the areas of needed technical assistance outlined in their annual applications. In the State MCH Block Grant applications, health disparities, which include disparities in the Black and White Infant Mortality Rates, and healthy perinatal and birth outcomes are frequently identified areas of needed technical assistance.

The FY 2012 Enacted level included appropriations language which provided SPRANS set aside funds for Oral Health ($3.8 million); Sickle Cell ($3.0 million); Epilepsy ($3.7 million); and Fetal Alcohol ($0.48 million).

Funds were also used to support a survey using the State and Local Area Integrated Telephone Survey (SLAITS) mechanism, which utilizes the sampling frame of the ongoing CDC-Sponsored Immunization Survey (CSIS). SLAITS provides the capacity to field surveys on a wide range of health and welfare related topics using the CSIS screening sample. The survey provides representative, reliable and previously unavailable information on: 1) special healthcare needs among children in 50 States and the District of Columbia; and 2) the competency of the service system in meeting the needs of these children and their families.

Affordable Care Act

The Maternal and Child Health Block Grant is a payer of last resort for Medicaid and private insurance. In addition to this status, MCHBG funds support a wide range of activities including infrastructure and system building; research, training, technical assistance; outreach, case management, health education services, and other enabling support.

At this time, HRSA does not anticipate that the implementation of the Affordable Care Act will reduce the need for MCHBG funding. Expanded insurance coverage will not support many of the services currently funded through the block grant, such as home visiting services, maternal and child health, research, and care coordination and case management services as described above. MCHBG funds will remain necessary to build and maintain the public health infrastructure that will help support ACA implementation. Further, the expanded coverage through Medicaid and the essential benefits package required of private insurance in marketplaces are unlikely to support the intensive services that Children with Special Health Care Needs require, maintaining MCHBG's status as a payer of last resort. Further, ACA affects the insurance coverage of less than 10 percent of children nationally, and as such the population seeking services supported through the MCHBG is not likely to shrink significantly in States.

Funding History

FY	Amount
FY 2005	$723,928,000
FY 2006	$692,521,000
FY 2007	$693,000,000
FY 2008	$666,155,000[118]
FY 2009	$662,121,000[119]
FY 2010	$660,710,000
FY 2011	$656,319,000
FY 2012	$638,646,000
FY 2013	$649,046,000
FY 2014	$638,646,000

Budget Request

The FY 2014 Budget Request is $638,646,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. Title V is the only Federal program that focuses solely on improving the health of all mothers, adolescents and children, whether insured or not, through a broad array of public health and community-based programs that are designed and carried out through well-established Federal/State partnerships. The budgeted funds will help State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as direct healthcare services where no services are available. In these latter roles, Title V programs serve as a safety net for uninsured and underinsured children, including CSHCN. Title V continues to play a valuable, complementary role to CHIP and Medicaid programs, and will continue to do so as ACA is implemented.

The FY 2014 targets for the number of children served by the Title V Block Grant and the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage are 31 million and 14 million, respectively. Relative to the rate of infant mortality, the FY 2014 target is 6.1 per 1,000 births.

The MCHB will continue to monitor emerging issues and areas of needed technical assistance in providing technical support to the States. In addition, the MCHB will continue to explore promising models and effective strategies that promote improved maternal and child health outcomes.

SPRANS and CISS funds will support innovative projects in the areas of: applied and translational research that has the potential to improve health services and care delivery, and to promote health and wellbeing among MCH populations; MCH workforce training in areas such as pediatric pulmonary centers, , behavioral health, , nutrition, schools of public health, and adolescent health; and a variety of MCH Improvement Projects (MCHIP) including: adolescent health; SIDS; “Bright Futures” guidelines for practitioners; medical homes; early childhood

118 Reflects moving $20 million to the Autism and Other Developmental Disorders Program.

119 Reflects moving $6.9 million to the Newborn Screening for Heritable Disorders Program.

comprehensive care systems; and oral health disease prevention and early treatment interventions. SPRANS and CISS both complement and help ensure the success of State Title V, Medicaid, and CHIP programs, building community capacity to create family-centered, integrated systems of care for mothers and children, including children with special healthcare needs.

In addition, Title V funds the only statutorily required genetic services program. This program funds initiatives to facilitate the early identification of children with genetic conditions and works to increase public and professional knowledge of how genetic risk factors affect health in order to create more responsive systems of care. The newborn screening and genetics public health infrastructure activities are to help support State newborn screening and genetics programs, integrate newborn and genetic screening programs with other community services and medical homes, and strengthen existing newborn and genetic screening and service programs. The programs also are established to aid State MCH officials, health care providers, public health professionals and families, and individuals respond to new scientific findings and technologies in the fields of genetic medicine and newborn screening. Special emphasis is being given to the financial, ethical, legal, and social implications of these issues and technologies for maternal and child health populations.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, and follow-up performance reviews, and Information Technology costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
10.I.A.1: Increase the number of children served by the Maternal and Child Health Block Grant *(Output)*	FY 2011: 37.4M Target: 31M (Target Exceeded)	33M	31M	-2M
10.I.A.2: Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage *(Output)*	FY 2011: 14.8M Target: 13M (Target Exceeded)	14M	14M	Maintain

Long Term Objective: Promote outreach efforts to reach populations most affected by health disparities

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2011: 2.2 to 1[120] Target: 2.1 to 1 (Target Not Met)	2.1 to 1	2.1 to 1	Maintain

Long Term Objective: Promote effectiveness of healthcare services.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
10.III.A.1: Reduce the infant mortality rate (Baseline - 2005: 6.9/1,000) *(Outcome)*	FY 2011: 6.1 per 1,000[120] Target: 6.6 per 1,000 (Target Exceeded)	6.6 per 1,000	6.1 per 1,000	-0.5 per 1,000
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2011:[121] 8.1% Target: 8.2% (Target Exceeded)	8.2%	8.1%	-0.1% point
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)* (New Baseline- FY 2006: 69%)[122]	FY 2008: 71%[123] (Target Not In Place)	70%	72%	+2% point

[120] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 6, October 2012.
[121] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Births: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 5, October 2012.
[122] A new FY 2006 baseline and the FY 2007 result for this measure are based on the use of the 2003 Revised U.S. Standard Birth Certificate. The FY 2007 – FY 2010 targets were established based on the use of the 1989 unrevised

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates *(Outcome)*	FY 2010: 74.5%[124] Target: 76% (Target Not Met)	76%	76%	Maintain
10.3: Increase maternal survival rate (deaths/100,000 live births) *(Outcome)*[125]	FY 2007: 12.7 to 100,000[126]	N/A	N/A	N/A

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	59	59	59
Average Award	$9,161,331	$9,310,627	$9,161,085
Range of Awards	$145,941 – $41,396,678	$148,319 – $39,860,101	$145,937 – $38,776,798

Birth Certificate. Therefore, the targets and results should not be compared until FY 2011 when targets and results are both based on the Revised Birth Certificate.

[123] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Expanded Data from the New Birth Certificate, 2008, Vol. 59, No. 7, July 2011.

[124] Source: Title V Information System, HRSA/MCHB (https://mchdata.hrsa.gov/TVISReports).

[125] This is a long-term measure with no annual targets.

[126] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2007, Vol. 58, No. 19, May 2010.

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
State	**FY 2012[127] Estimate**	**FY 2013[128] Estimate**	**FY 2014[129] Estimate**	**Difference +/- 2012**
Alabama	11,461,562	11,479,656	11,330,579	-130,983
Alaska	1,092,039	1,063,010	1,056,480	-35,559
Arizona	6,809,108	7,408,240	7,227,349	418,241
Arkansas	6,938,012	7,080,121	6,933,053	-4,959
California	41,396,678	39,860,101	38,776,798	-2,619,880
Colorado	7,115,761	7,601,930	7,481,915	366,154
Connecticut	4,654,331	4,687,435	4,606,936	-47,395
Delaware	1,940,952	2,002,239	1,977,797	36,845
District of Columbia	7,028,937	6,938,225	6,914,931	-114,006
Florida	18,476,827	19,405,864	19,061,138	584,311
Georgia	15,882,994	16,975,235	16,758,642	875,648
Hawaii	2,229,869	2,153,169	2,168,066	-61,803
Idaho	3,179,804	3,305,006	3,259,112	79,308
Illinois	21,195,146	21,543,624	21,235,657	40,511
Indiana	11,565,798	12,363,907	12,229,142	663,344
Iowa	6,442,404	6,600,344	6,540,643	98,239
Kansas	4,626,932	4,817,674	4,768,410	141,478
Kentucky	11,132,155	11,273,605	11,094,614	-37,541
Louisiana	13,011,785	12,264,767	12,058,581	-953,204
Maine	3,357,358	3,356,534	3,315,661	-41,697
Maryland	11,799,051	11,729,847	11,651,502	-147,549
Massachusetts	11,257,762	11,098,681	11,009,613	-248,149
Michigan	18,488,255	19,329,811	19,005,189	516,934
Minnesota	8,939,765	9,232,937	9,145,717	205,952
Mississippi	9,510,148	9,478,847	9,235,418	-274,730
Missouri	12,145,754	12,362,826	12,172,116	26,362
Montana	2,387,955	2,343,812	2,295,637	-92,318
Nebraska	3,964,846	4,016,847	4,001,795	36,949
Nevada	1,716,274	2,053,013	2,031,916	315,642
New Hampshire	1,976,951	1,983,933	1,970,283	-6,668
New Jersey	11,434,905	11,531,053	11,335,224	-99,681

[127] Based on actual FY 2012 funds and Census 2000 poverty data
[128] Based on FY 2013 President's Budget and ACS 2010 1-year poverty data
[129] Based on FY 2013 President's Budget and ACS 2010 3-year poverty data

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
State	**FY 2012[127] Estimate**	**FY 2013[128] Estimate**	**FY 2014[129] Estimate**	**Difference +/- 2012**
New Mexico	4,221,754	4,149,023	4,084,260	-137,494
New York	40,036,911	38,423,889	37,751,061	-2,285,850
North Carolina	16,274,909	17,523,605	17,263,911	989,002
North Dakota	1,793,828	1,760,037	1,739,014	-54,814
Ohio	21,672,017	22,542,199	22,239,525	567,508
Oklahoma	7,102,438	7,203,856	7,017,781	-84,657
Oregon	6,092,903	6,296,451	6,236,877	143,974
Pennsylvania	23,930,276	23,955,146	23,566,766	-363,510
Rhode Island	1,725,213	1,649,641	1,637,152	-88,061
South Carolina	11,201,945	11,547,359	11,443,959	242,014
South Dakota	2,220,826	2,183,177	2,152,844	-67,982
Tennessee	11,427,415	11,973,297	11,760,837	333,422
Texas	33,137,934	35,234,848	34,273,755	1,135,821
Utah	5,934,990	6,156,085	6,154,101	219,111
Vermont	1,676,416	1,670,523	1,650,658	-25,758
Virginia	12,161,027	12,295,569	12,091,374	-69,653
Washington	8,800,285	8,972,364	8,841,441	41,156
West Virginia	6,327,575	6,157,483	6,075,761	-251,814
Wisconsin	10,659,871	11,040,552	10,944,345	284,474
Wyoming	1,236,343	1,204,659	1,205,671	-30,672
SUBTOTAL	**520,794,994**	**529,282,056**	**520,781,007**	**-13,987**
American Samoa	486,467	494,394	486,454	-13
Guam	751,321	763,565	751,301	-20
Marshalls	227,016	230,716	227,010	-6
Micronesia	513,493	521,861	513,479	-14
Northern Marianas	459,441	466,929	459,429	-12
Palau	145,941	148,319	145,937	-4
Puerto Rico	15,664,227	15,919,497	15,663,806	-421
Virgin Islands	1,475,616	1,499,663	1,475,577	-39
SUBTOTAL	**19,723,522**	**20,044,944**	**19,722,993**	**-529**
TOTAL Resources	**540,518,516**	**549,327,000**	**540,504,000**	**-14,516**

Autism and Other Developmental Disorders

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$47,142,000	$47,909,000	$47,142,000	---
FTE	6	6	6	---

Authorizing Legislation - Section 399BB of the Public Health Service Act.

FY 2014 Authorization $48,000,000

Allocation Methods:

- Direct Federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The Combating Autism Act of 2006 authorized a program for early detection, education and intervention activities on autism and other developmental disorders. This Program supports activities to:

- provide information and education on autism spectrum disorders (ASD) and other developmental disabilities (DD) to increase public awareness;
- promote research into the development and validation of reliable screening tools and interventions for autism spectrum disorders and other developmental disabilities and disseminate information;
- promote early screening of individuals at higher risk for autism spectrum disorders and other developmental disabilities as early as practicable, given evidence-based screening techniques and interventions;
- increase the number of individuals who are able to confirm or rule out a diagnosis of autism spectrum disorders and other developmental disabilities; and
- increase the number of individuals able to provide evidence-based interventions for individuals diagnosed with autism spectrum disorders or other developmental disabilities.

In FY 2008, Congress appropriated $36,354,000 for this program of which approximately $20 million was moved from the Maternal and Child Health Block Grant training programs for Leadership Education in Neurodevelopmental and Related Disabilities (LEND) and Developmental Behavioral Pediatrics. Funds were used to expand these interdisciplinary training programs as well as support the following programs: autism intervention research network grants to study the effectiveness of interventions for autism and related developmental disabilities; demonstration grants to develop models of systems of services for children with autism and other developmental disabilities; grants to disseminate current and accurate

information to families and consumers on early identification, diagnosis and access to services; grants to disseminate screening intervention and guideline information; and other technical assistance and evaluation.

In FY 2009, Congress appropriated an additional $6,000,000 to: expand the LEND Program; support autism intervention research grants to study evidence-based practices for interventions to improve the health and well-being of children and adolescents with ASD and other DD; support grants that analyze secondary data, expand demonstration grants to develop models of systems of services for children with ASD and other DD; expand grants to resource centers to disseminate ASD information to families and consumers; disseminate screening intervention and guideline information; and support for other technical assistance and evaluation activities.

In FY 2010, Congress appropriated an additional $6,000,000 to expand the LEND interdisciplinary training programs, including four new planning grants; expand the autism intervention research grants, and to support additional State demonstration grants, supplements to developmental-behavioral pediatrics training programs, resource centers and a national evaluation. Developmental-behavioral pediatrics training programs have developed nine case studies on ASD and will disseminate to pediatric residency training programs and practicing primary care providers to improve screening, diagnosis and treatment of ASD.

In FY 2011, Congress appropriated $47,708,000. This budget supported 43 LEND interdisciplinary training programs, providing services and training to 41 States, and their reach extends beyond those States because of partnerships formed and services provided across State lines; 10 Developmental-Behavioral Pediatrics training grants; three research networks and 15 autism intervention research projects examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research; and 13 State demonstration grants, resource centers, and a national evaluation. All activities continue to be coordinated with the Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. public awareness campaign; the State Demonstration Program jointly sponsors the campaign in four States – Washington, Missouri, Utah, and Alaska.

In FY 2012, Congress appropriated $47,142,000. This budget supports 43 LEND interdisciplinary training programs, providing services and training to 41 States, with many extending training and services across multiple States, further extending their reach; 10 Developmental-Behavioral Pediatrics training programs; three research networks and 14 autism intervention research projects examining areas of particular interest to families and many addressing the needs of underserved populations; and 13 State demonstration grants, two resource centers, and a national evaluation.

The FY 2013 Annualized CR is $47,909,000. This budget supports 43 LEND interdisciplinary training programs, providing services and training to 41 States, with many extending training and services across multiple States, further extending their reach; 10 Developmental-Behavioral Pediatrics training programs; four research networks and 13 autism intervention research projects examining areas of particular interest to families and many addressing the needs of underserved populations; 13 State demonstration grants (nine state implementation grants and 4 state planning

grants); two resource centers; and a national evaluation. All activities continue to be coordinated with the CDC's activities and with priorities of the Interagency Autism Coordinating Committee (IACC).

Progress Report – Selected Findings

In calendar year 2012, the GAO reviewed HRSA's oversight of the Combating Autism Act programs. Findings from the GAO review will be shared with Congress in early 2013.

A Report to Congress with findings to date was submitted to the National Institute of Mental Health (NIMH) in December 2010. An updated Report to Congress including findings from HRSA's Combating Autism Act investments through September 30, 2011 will be sent to Congress in early 2013. A new study starting with investments from September 30, 2011 to present is currently underway and will contribute to the HHS 2013 Report to Congress. Selected findings from the completed evaluation are presented here.

REDUCING BARRIERS

Reported increases in the number of children that received diagnostic evaluations over the course of the grant period provide an early indication of progress toward the goal of reducing barriers to ASD services. In 2009–2010, the 39 LEND grantees supported with CAAI [(Combating Autism Act Initiative)] funding collectively provided diagnostic evaluations to more than 35,000 children. The following year, the number of diagnostic evaluations provided through a LEND program-affiliated clinic exceeded 44,000. Including the children who received diagnostic evaluations from a CAAI-supported LEND program in 2008–2009, nearly 92,000 children were evaluated over the 3-year grant period.

Grantees further worked to improve access to ASD services in several ways. To enable more families to get the services they need regardless of their ability to pay, the grantees helped advance health insurance and billing reforms. To create more coordinated systems of care for ASD, they mapped existing resources, identified gaps in services, and worked to build more interdisciplinary collaboration among providers from different disciplines, such as medicine and education.

The LEND and DBP [(Developmental-Behavioral Pediatrics)] grantees provided Title V and other agencies with technical assistance to expand community-based services for ASD. The research grantees developed and disseminated ASD toolkits and clinical guidelines to support health care providers and families. Finally, all grantees focused on the particular needs of underserved populations as a means of reducing disparities in access to ASD services.

TRAINING

To address the shortage of health care professionals who are qualified to provide screening and diagnostic evaluation for ASD and other DD, the LEND and DBP programs expanded their training resources and assisted local agencies and practices in building their capacity to provide

community-based ASD services. The LEND and DBP programs expanded the number of professionals in the pipeline by:

- Increasing the number of trainees enrolled in their programs. During the 2009–2010 grant year, the LEND and DBP programs collectively trained close to 2,500 medium-term and 1,400 long-term trainees.[130]
- The following grant year, the number of medium- and long-term trainees increased by 13 percent and 22 percent, respectively.
- By the 2011-2012 grant year, the LEND and DBP programs collectively trained 3,039 medium-term and 1,474 long-term trainees.
- Increasing the number of trainees that received ASD-focused didactic training. Between the 2009–2010 and 2010-2011 grant years, the number of medium-term trainees enrolled in ASD-focused coursework increased by 8.2 percent and the number of long-term trainees increased by 13.6 percent.
- Providing more clinical training opportunities focused on ASD screening and diagnosis. In the final year of the grant, close to 1,500 medium-term trainees and more than 1,100 long-term trainees had participated in clinical practices covering ASD screening, diagnostic evaluation, and/or intervention.

The grantees also responded to the training needs of practicing pediatricians and other professionals who had limited experience identifying ASD in children. Between 2009 and 2011, the LEND and DBP grantees collectively offered more than 1,600 continuing education (CE) events pertaining to ASD screening, diagnostic evaluation, and evidence-based interventions for children with ASD. In 2012 alone, the LEND and DBP grantees provided 917 CE events. From 2009-2011, these grantees also offered more than 4,000 outreach trainings related to valid and reliable screening and diagnostic tools, and/or evidence-based interventions for ASD and other DD, with the numbers increasing from year to year. In 2012 alone, they offered 2,136 outreach trainings.

AWARENESS BUILDING

To promote early screening, diagnostic evaluation, and intervention, the grantees engaged in various strategies aimed at building awareness of ASD among providers, parents, and the public. A few of their accomplishments are highlighted below:

- To raise public awareness, the State grantees disseminated messages about ASD through various media outlets, including film events, radio and televised public service announcements, and library campaigns. They also developed web sites and web portals for online dissemination of ASD materials. Additionally, they distributed screening kits, autism toolkits, as well as print materials and resources to medical providers and other professionals. Family-focused materials included resource roadmaps, directories, navigator guides, and autism guidebooks.

[130] Medium-term trainees are those who complete between 30 and 200 hours of training during 1 academic year. Long-term trainees are those who complete more than 300 hours of training.

- During the grant period, the LEND and DBP training programs developed and/or disseminated close to 2,000 ASD-related educational products to health care practices and providers, educators, and parents.
- The research grantees reached more than 4,000 health professionals through various training events, such as grand rounds presentations and scientific conference presentations. Collectively, they reached more than 6,000 individuals through community outreach sessions.

RESEARCH

To improve the health and well-being of children with ASD, the research grantees conducted studies addressing such topics as the efficacy of ASD interventions, early identification of ASD in minority populations, family well-being, and transition and developed consensus-based guidelines to support families and professionals in providing treatment for children with ASD. These tools may, for example, help to quickly assess a child's engagement level on the playground or help parents manage their children's sleep behavior. Fifty-seven manuscripts have been published to date.

In addition to conducting studies, the research grantees developed guidelines to support evidence-based clinical decision-making, and toolkits to support clinicians and parents in identifying and treating the medical and behavioral issues that commonly occur in children with ASD. Together, the research grantees developed eight medical guidelines, one comprehensive guideline report, 14 toolkits for providers and parents to use in monitoring and managing ASD symptoms, and seven new behavioral measures for assessing a child's progress over time. More specifically:

- The Autism Intervention Research Network on Physical Health (AIR-P) drafted eight clinical guidelines in the areas of sleep, gastrointestinal problems, neurology, genetics and metabolic screening decisions, and medication choice and monitoring. Three of these guidelines (insomnia, constipation and medication choice) have since been finalized and were published in a Pediatrics Journal Supplement on HRSA CAAI Autism Intervention Research Programs in November 2012.
- The Autism Intervention Research Network on Behavioral Health (AIR-B) developed a comprehensive consensus-based guidelines report assessing the scientific evidence on behavioral, educational, and medical interventions and their impact on ASD symptoms. This report was published in the Pediatrics journal supplement of HRSA CAAI autism intervention research programs in November 2012.
- To help parents and professionals manage health-related concerns that are commonly associated with ASD, the AIR-P network developed toolkits on medication management, sleep management, behavioral management, and tools for day-to-day living. The AIR-P network is currently developing a toolkit focusing on transition of youth and young adults.
- The AIR-B network developed new validated measures to track a child's progress and assess the effectiveness of behavioral ASD interventions over time. These new measures can be used by a diverse group of care providers in a variety of settings.
- The Developmental-Behavioral Pediatrics Research Network (DBPNet) was funded in

FY 2010 and has established a collaborative scientific and clinical research network to foster research activities for children with ASD and other developmental disabilities.[131] DBPNet has developed the national research agenda for Developmental-Behavioral Pediatrics research through the Delphi process. The DBPNet is currently conducting studies on clinical practice variation, feasibility of electronic health record data in describing clinical practice, and has completed a study on research training in DBP fellowship programs. The DBPNet fosters the development of new investigators in developmental-behavioral pediatrics. The Network has awarded a Young Investigator to conduct a multi-site pilot study with mentorship from senior investigators across the network to study the association of maternal immune status with autism severity and behavioral impairments. DBPNet continues to strengthen the DBP research infrastructure by fostering the development of the next generation of DBP researchers, supporting research opportunities for its Network investigators, and promoting collaboration with and involvement of DBP researchers external to the Network in DBPNet studies.

- In collaboration with all HRSA/MCHB funded CAAI autism intervention research programs, the AIR-P Network spear-headed the development of a journal supplement on HRSA CAAI autism intervention research programs and findings. The supplement includes manuscripts from select HRSA CAAI autism intervention research projects. The journal supplement was published in Pediatrics in November 2012 and covers a rich and diverse compilation of research and practice improvement related to the care and well-being of children and youth with autism and related neurodevelopmental disorders.

Other significant R40 research projects explore the use of family navigators to facilitate identification and diagnosis of ASD among Latino families; intervention strategies for improving the health care transition for youth with ASD; a culturally compatible parent to parent model of support and service coordination for families with a preschool child with ASD; and teleconsultation training for parents to perform ABA therapy for their rural, underserved children with ASD.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$47,898,000
FY 2011	$47,708,000
FY 2012	$47,142,000
FY 2013	$47,909,000
FY 2014	$47,142,000

[131] Blum, N.J.; DBPNet Steering Committee (2012) The Developmental-Behavioral Pediatrics Research Network: another step in the development of the field. Journal of Developmental Behavioral Pediatrics.33(1):78-83.

Budget Request

The FY 2014 Budget Request is $47,142,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. Comparable activities will be supported in FY 2014 including 43 LEND training programs, 10 developmental-behavioral pediatrics training programs, nine active State implementation grants, four State planning grants, four autism intervention research networks, and 13 research grants examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's Strategic Plan for Autism Spectrum Disorder Research as well as addressing the needs of underserved populations. All activities will continue to be coordinated with the Interagency Autism Coordinating Committee and, in particular, with the CDC's Learn the Signs.Act Early. public awareness campaign.

A program evaluation was completed in fall 2011 and assessed all aspects of the program (research, training and State demonstration efforts). A Report to Congress including these full results will be submitted in early 2013.

In FY 2014 funds will be used to continue and expand activities initiated in FY 2008 to:

- Provide information, education and coordination;
- Promote research into evidence based practices for interventions and the development of reliable screening tools;
- Promote the development, dissemination and implementation of guidelines;
- Promote early screening and intervention;
- Train providers to diagnose and provide care for individuals with ASD and other DD;
- Develop innovative strategies to integrate and enhance existing investments, including translating research findings on interventions, guidelines, tools and systems management approaches to training settings, communities and into practice; and
- Promote life-course considerations, from developmental screening in early childhood to transition to adulthood issues.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Grants:			
LEND	$27,756,891	$27,756,891	$27,756,891
DBP	$1,857,203	$1,857,203	$1,857,203
Research	$9,591,007	$9,591,007	$9,591,007
State Demonstration	$2,997,671	$2,997,671	$2,997,671
Resource Centers	$941,051	$941,051	$941,051
Number of Awards	85	85	85
Average Award	$507,574	$507,574	$507,574

Traumatic Brain Injury

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$9,760,000	$9,919,000	$9,760,000	---
FTE	---	---	---	---

Authorizing Legislation - Sections 1252 and 1253 of the Public Health Service Act.

FY 2014 Authorization .....Expired

Allocation Methods……..….Formula grant/Competitive grant

Program Description and Accomplishments

The Traumatic Brain Injury (TBI) Grant Program funds the development and implementation of statewide systems that ensures access to comprehensive and coordinated TBI services including: transitional services, rehabilitation, education and employment, and long-term community support. On average, 1.7 million Americans will sustain a TBI each year[132]. It is estimated that up to 90,000 of these individuals will experience long-term, sometimes life-long, impairments as a result of their injury[133]. Such statistics likely underestimate the actual incidence of TBI because surveillance only captures injuries for which medical treatment is sought. Timely, comprehensive treatment is vital not only to save lives, but also to improve the quality of life for TBI survivors.

TBI can cause a range of symptoms, which may include, but is not limited to, memory loss, difficulty concentrating, confusion, irritability, personality changes, fatigue, and headaches. Individuals with TBI may need a variety of services and supports, including rehabilitation, counseling, academic and vocational accommodations, independent living assistance, transportation assistance, and vocational training. These services and supports are often fragmented across different State systems of care, making access difficult for families. Through the TBI Program, State and Territorial governments receive funding to help individuals with TBI and their families receive the comprehensive care and services they need to manage ongoing conditions caused by the injury.

[132]Faul M, Xu L, Wald MM, Coronado VG. Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002–2006. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010. Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

[133]Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

The TBI Program consists of two distinct grant programs: 1) the State Implementation Partnership Grants (competitive grant), and 2) the State Protection and Advocacy Systems Grants (formula grant).

State Implementation Partnership Grants

Each State Implementation Partnership grantee must have or develop the following four core components: 1) a Statewide Needs and Resources Assessment, 2) a statewide action plan, 3) a Statewide Advisory Board, and 4) a designated State agency responsible for carrying out the activities of the grant. A performance goal for this program is to "increase the number of total State partnerships and/or collaborations with governmental and non-governmental organizations." The FY 2012 data show that 441 partnerships have been forged since 2009. The Program anticipates that the number of collaborations/partnerships in which TBI grantees participate will be 350 in FY 2014, as a new cohort of grantees will be active and begin forging new partnerships.

Since the program's inception in 1996, it has evolved from being a demonstration program to a full implementation program with the grants developing from planning grants to full implementation partnership grants. The current authorization for the Program is more prescriptive in terms of both sustainable systems change in States and in how grant funds ought to be used to accomplish this over-arching goal.

For 2009, the guidance for new awards was changed to reflect an increased emphasis on those special populations with high rates of TBI that have not necessarily received adequate attention in the past, including veterans, children and youth, incarcerated juveniles, those with substance abuse problems, as well as Native Americans and African Americans. The amount of each award was raised to $250,000 per State, and 17 new awards were made in FY 2009. There were three new awards made in 2010 and one additional award in 2011. All of the States funded have made progress in developing and linking accessible TBI services and supports.

Other activities include educating consumers, families, and professionals on available TBI resources/services, screening for TBI in criminal/juvenile justice facilities, homeless shelters, and schools, training health professionals in various disciplines to identify and effectively serve individuals with TBI, providing case management services to coordinate care across treatment areas, and assisting families who are transitioning from one system to another (e.g., military discharge to community re-entry, hospital acute care to school re-entry).

State Protection and Advocacy Systems Grants

Section 1253 of the Public Health Service Act recognizes that State Protection and Advocacy (P&A) systems are critical to achieving the goals and objectives of the TBI Program. In FY 2003, grants were awarded to all 57 P&A systems to evaluate capacity and to develop plans to ensure P&A services, including individual and family advocacy, self-advocacy training, specific self-advocacy assistance, information and referral services, and legal representation. These formula grants continue to be awarded to 57 States, Territories, and one Native American Consortium. A key performance measure for this program will be to "increase the number of

trainings conducted by the TBI Protection and Advocacy Grant Program." An additional new performance measure will assess not only the number but also the impact of P&A activities by asking providers and individuals with TBI and their families if the training and information provided helped recipients to better provide/access TBI services.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
State Grants for Demonstration Projects	$5,265,048	$5,265,048	$5,265,048
State Protection and Advocacy Grants	$3,272,375	$3,272,375	$3,272,375

The TBI program also provides for a National Technical Assistance Center.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$9,918,000
FY 2011	$9,878,000
FY 2012	$9,760,000
FY 2013	$9,919,000
FY 2014	$9,760,000

Budget Request

The FY 2014 Budget Request is $9,760,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. Starting in FY 2009, as grants were competed for new awards, the amount of the grant award was increased to $250,000, which resulted in awards to 17 States. There were three new awards made in 2010 and one additional award in 2011.

21 grants are anticipated to be awarded in FY 2014 the same as FY 2012 Enacted. This competition required larger grant awards to allow the States to create a State-wide system of care that can work with all the State-level agencies (Education, Vocational Rehabilitation, Social Services, Mental Health and Substance Abuse, the State Corrections System, Housing, and Transportation) that play a role in the overall State plan that ensures a comprehensive and sustainable system of care for individuals with TBI and their families. TBI Protection and Advocacy grants will continue to receive a total of $3.2 million in FY 2014 the same as FY 2012 Enacted.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
11.V.B.6 Percentage of grantees that achieve the 4 core components of the TBI Implementation Partnership Grant Program within the 4 year project period. [134] (Developmental) (*Output)*	FY 2012: 100% Target: N/A (Baseline)	N/A	100%	N/A
11.V.B.4. Number of total State partnerships and/or collaborations with governmental and non-governmental organizations. (*Output)*	FY 2012: 441 Target: 154 (Target Exceeded)	154	350[135]	+196
11.V.B.8. Increase the number of individuals that receive trainings conducted by the TBI Protection and Advocacy Grant Program. [136] (Developmental) (*Outcome)*	FY 2012: 38,457 Target: N/A (Baseline)	N/A	38,000	N/A
11.V.B.9 Proportion of individuals with TBI and/or their families who report that a State Implementation Partnership grantee provided or helped them to better access TBI-related services.[137] (Developmental)	N/A	N/A	N/A	N/A
11.V.B.10 Proportion of professionals participating in a HRSA grantee activity who	N/A	N/A	N/A	N/A

[134] Baseline data for this developmental long-term measure was established for FY 2012 using grantees' annual progress reports, and was used to establish the new target for FY 2014.
[135] This target is lower than the FY 2012 result because it reflects the activities of a new cohort of grantees.
[136] Baseline data for this developmental measure was established for FY 2012 using grantees' annual progress reports and was used to establish the new target for FY 2014.
[137] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY 2016.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
report that they are better able to assess the needs of TBI survivors and/or their families and facilitate improved access to rehabilitative and other services.[138] (Developmental)				
11.V.B.11 Proportion of persons with TBI and/or their families who report that a HRSA TBI Protection and Advocacy Grantee helped them to better access services.[139] (Developmental)	N/A	N/A	N/A	N/A

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	21/57[140]	21/57[140]	21/57[140]
Average Award	$250,000/$57,000[140]	$250,000/$57,000[140]	$250,000/$57,000[140]
Range of Awards	$202,000-$281,000/ $20,000-$184,000[140]	$202,000 - $281,000/ $20,000-$184,000[140]	$202,000-$281,000/ $20,000-$184,000[140]

[138] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY 2016.
[139] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY 2016.
[140] State Grantees/Protection and Advocacy Grantees

Sickle Cell Services Demonstration Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$4,665,000	$4,741,000	$4,665,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 712(c) of the American Jobs Creation Act of 2004.

FY 2014 Authorization .....Expired

Allocation Methods……..……Competitive co-operative agreement/Contract

Program Description and Accomplishments

The purpose of the Sickle Cell Disease Demonstration Program is to improve the care of sickle cell disease by increasing access to disease-modifying therapies in the context of a medical home model. The program has been tasked with creating strategies to improve access to hydroxyrea therapy, improve timeliness of pain therapy in the emergency room and increase capacity to educate providers on best practices in sickle cell care.

The Sickle Cell Service Demonstration Program was created in FY 2005 to develop systemic mechanisms for treatment of Sickle Cell Disease (SCD) and the prevention of morbidity and mortality associated with the condition. Investments in SCD service delivery, safety net access points, and the preparation of primary care clinicians have been created to serve this underserved population. Over the past eight years a focus on service infrastructure has included:

- identification and establishment of genetic counseling,
- testing and other education opportunities for individuals, families and communities;
- provision of educational training sessions; and
- engagement opportunities for health care providers.

The Sickle Cell Service Demonstration Program has been involved in the following activities to meet objectives and address priority areas of the Program:

- Technical assistance/information exchange
- Developing and sustaining partnerships
- Materials review and development
- Collection, coordination, and distribution of Sickle Cell Service Demonstration Program data, best practices, and findings.

Efforts involve surveillance and analysis of hemoglobinopathy data; Quality Improvement (QI) Learning Collaborative sessions and targeted technical assistance; evaluation of treatment and

management guidelines; translation, dissemination and education; and practice innovation. HRSA is collaborating with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to adapt and institutionalize the NIH *Guidelines for Care of Sickle Cell Disease* and ensure data elements can be used across programs as well as address Healthy People 2020 objectives.

Funding History

FY	Amount
FY 2010	$4,740,000
FY 2011	$4,721,000
FY 2012	$4,665,000
FY 2013	$4,741,000
FY 2014	$4,665,000

Budget Request

The FY 2014 Budget Request is $4,665,000. The FY 2014 Request is the same as the FY 2012 Enacted Level, and includes a legislative proposal to reconfigure the program's current approach, and will (1) support seven geographically distributed demonstration projects, with nationwide exposure for enhanced access to comprehensive, coordinated, culturally-effective, and family centered high quality services for individuals with sickle cell disease; (2) expand and upgrade data collection efforts, improve capacity and analysis to generate evidence of effectiveness through evaluating network activities and outcomes; and (3) focus on increasing the number of primary care providers that are involved with the care of individuals with sickle cell disease by increasing capacity of university medical centers and hematologists to provide technical assistance and educational opportunities.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	9	9	7
Average Award	$378,000	$378,000	$486,000
Range of Awards	$378,000 – $378,000	$378,000 – $378,000	$430,000 – $540,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$18,660,000	$18,963,000	---	-$18,660,000
Prevention Fund	---	---	$18,660,000	+$18,660,000
Total	$18,660,000	$18,963,000	$18,660,000	---
FTE	5	5	5	---

Authorizing Legislation - Section 399M of the Public Health Service Act.

FY 2014 Authorization ..... SSAN

Allocation Methods……Competitive grant/Co-operative agreement/Contract

Program Description and Accomplishments

The James T. Walsh Universal Newborn Hearing Screening Program began in FY 2000 and supports the following Healthy People 2020 Objectives: (1) physiologic testing of newborn infants prior to their hospital discharge; (2) audiologic evaluation by three months of age; and (3) entry into a program of early intervention by six months of age with linkages to a medical home and family-to-family support.

In FY 2008, the Maternal and Child Health Bureau awarded competitive grants to States to implement the Program, and to one national technical assistance center. Collaboration with the Centers for Disease Control and Prevention (CDC) and National Institutes of Health's National Institute on Deafness and Other Communication Disorders is ongoing to coordinate programs at the national and State levels. For FY 2009 and FY 2010, additional supplemental funds were directed toward reducing loss-to-follow-up by implementing strategies to assure that infants identified through screening receive timely diagnosis and early intervention, and that parents are connected to ongoing family-to-family support. In 2012, competing continuation awards were made to 58 States/jurisdictions. South Dakota has consistently declined to apply since 2003.

The Universal Newborn Hearing Screening Program has been successful in increasing the percentage of newborns screened for hearing loss prior to hospital discharge. In 2005, 95 percent of newborns were screened for hearing loss prior to hospital discharge, exceeding the target of 94 percent according to data collected by the National Center for Hearing Assessment and Management. In FY 2006, the (CDC's) National Center for Birth Defects and Developmental Disabilities (NCBDDD) began collecting State data for the first time on newborn hearing screening services. In FY 2010, data from the NCBDDD indicate that 98 percent of newborns were screened before one month of age, most before discharge from the newborn nursery. In addition, the Loss to Documentation/Followup (LTD/F) rate dropped from 46 percent to 39 percent. Although most of the States now have laws mandating hearing screening

for newborns, few have comprehensive reporting provisions. Hospitals report screening in nearly all U.S. hospitals, save military birthing hospitals. Service providers (audiologists, primary care practitioners and Early Intervention providers) in the continuum of services do not routinely report in many places.

An independent evaluation of the Program was completed in 2006. Findings were used to implement a quality improvement initiative. This initiative focused on implementation of recommendations for programmatic changes which have proven to be effective in reducing loss to follow-up. These strategies have been incorporated into subsequent grant guidance. Program funding includes a National Resource Center, staffing, costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$18,960,000
FY 2011	$18,884,000
FY 2012	$18,660,000
FY 2013	$18,963,000
FY 2014	$18,660,000

Budget Request

The FY 2014 Budget Request is $18,660,000, which is the same as the FY 2012 Enacted Level. The FY 2014 request will support 58 awards to assist the program in achieving the FY 2014 target of screening 98 percent of infants prior to hospital discharge.

The FY 2014 Budget funds this program through the Prevention and Public Health Fund (PPHF).

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.[141] *(Outcome)*	FY 2004: 20% (Baseline)	N/A	N/A	N/A

[141] This long-term measure does not have annual targets. The first long-term target was set for FY 2013.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age.[142] [143] (Baseline – FY 2009: 68%) *(Output)*	FY 2010: 67% (Target Not in Place)	N/A	70%	N/A
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. *(Output)*	FY 2010: 72% Target: 63% (Target Exceeded)	70%	75%	+5% Points
13.III.A.3: Percentage of infants screened for hearing loss prior to hospital discharge. *(0utput)*	FY 2010: 98% Target: 98% (Target Met)	98%	98%	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	58	58	58
Average Award	$251,000	$251,000	$251,000
Range of Awards	$135,000 – $279,000	$135,000-$279,000	$135,000-$279,000

[142] CDC has been collecting data annually since 2006. Baseline updated to reflect annual data collection. Previously data were collected by the National Center for Hearing Assessment and Management.
[143] This measure is to be tracked annually in light of new Part C of IDEA regulations which mandate collaboration with Title V programs including newborn hearing screening programs.

Emergency Medical Services for Children

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$21,116,000	$21,460,000	$21,116,000	---
FTE	3	3	3	---

Authorizing Legislation - Section 1910 of the Public Health Service Act.

FY 2014 Authorization $30,387,656

Allocation Method ..... ….Competitive grant/cooperative agreement

Program Description and Accomplishments

The Emergency Medical Services for Children (EMS-C) Program is the only Federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. The Institute of Medicine (IOM) and other national experts have stated that there are significant gaps across the country in providing quality care to children in emergencies. Pediatric emergency care begins with the 911 call through the delivery of the patient to the appropriate hospital and ultimately returning the child to the community. The mission of the EMS-C program is to reduce child and youth mortality and morbidity resulting from severe illness or trauma.

To improve the quality of pediatric emergency care, the EMS-C Program administers four main grant programs: 1) 58 State Partnership grants (one to each State, Territory and the Freely Associated States), 2) seven Targeted Issues grants that address issues of national significance, 3) six State Partnership Regionalization of Care demonstration grants that improve pediatric emergency care capacity in rural and tribal communities, and 4) six grants for the Pediatric Emergency Care Applied Research Network to conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine.

The EMS-C Program measures its impact through a combination of short-term and long-term measures. In the short term, the program focuses on the quality of care provided in the pre-hospital and hospital settings by assuring continuing pediatric education. Performance measures that require survey assessment are collected every 3 years, while self-reported data is collected annually. Each year, State grantees assess the adoption of required pediatric training for Basic Life Support (BLS) and Advanced Life Support (ALS) providers during recertification (Measure 14.V.B.2A & 2B). Through FY 2011, 43 grantees had adopted requirements for recertification of BLS providers and 45 grantees had adopted requirements for recertification of ALS providers.

Decreasing pediatric mortalities due to serious injury is a long-term outcome of the EMS-C Program that is tracked annually. Data from the Healthcare Cost Utilization Project (HCUP) is utilized to assess trends in pediatric mortality due to injuries. Between 2005 and 2009, there was a six percent reduction in pediatric hospital deaths due to severe injury which translates to approximately 5,678 children's lives saved. The EMS-C program assesses the percent reduction in pediatric injury mortality annually from the HCUP administrative data (Measure 14.1.A). Small reductions in absolute mortality rates can represent a significant number of lives saved, so an annual goal of 0.5 percent reduction is presented rather than the absolute rate decrease.

The EMS-C program tracks other health quality indicators that address the quality of care being delivered in States and territories as well as the permanence of EMS-C in State systems. Program requires all State/Territory grantees to collect data every three years for some measures.

In FY 2010, national survey data collected by Program grantees demonstrated the following results:

- Each State determines whether their ambulances that transport children have available all of the appropriate pediatric equipment. Success for this performance measure is when all ambulances transporting children in a State carry all of the necessary pediatric equipment. The results are presented first as the proportion of equipment carried on ambulances nationally, the proportion that have all of the equipment, and finally, the number of States with 100% compliance. Of the EMS vehicles responding to 911 calls for pediatric patients, representing 22,067 ambulances, Basic Life Support (BLS) ambulances had 91 percent of all the recommended pediatric equipment and Advanced Life Support (ALS) ambulances had 96 percent of all the recommended pediatric equipment. Although a majority of ambulances have the majority of essential equipment, only 22 percent of BLS ambulances and 39 percent of ALS ambulances had 100 percent of the recommended pediatric equipment. Only two entities, Hawaii and the District of Columbia, have all of the BLS recommended pediatric equipment and supplies (Measure 14.V.B.3A) and two entities, Maryland and the District of Columbia, have all the ALS recommended pediatric equipment and supplies on 100 percent of the ambulances (Measure 14.V.B.3B). Missing items include essential life saving equipment and therefore the Program continues to direct efforts to assure that 100 percent of the recommended equipment is on 100 percent of the ambulances in every State/Territory.

- In the hospital setting, the EMS-C program assesses whether significant progress is being made in implementing a pediatric recognition system in hospitals that are treating pediatric medical emergencies. Significant progress is defined as having developed and fully implemented a recognition program (Measure 14.V.B.4A). In FY 2011, 24 States had implemented such a program for medical emergencies. The EMS-C Program also assesses whether significant progress has been made in establishing a pediatric recognition system for hospitals treating pediatric traumatic injuries using the same definition above (Measure 14.V.B.4B). Through FY 2011, 48 States had implemented such a system for addressing pediatric traumatic emergencies.

The EMS-C Program focuses on specific initiatives to support the success of the overall mission of the program. In FY 2012, the program initiated a demonstration project with six awardees to look at innovative models to increase pediatric care in rural and tribal communities. Results of these projects will instruct other awardees on how to improve the delivery of pediatric emergency care in various systems of care. The delivery of quality pediatric emergency care is dependent on the availability of evidence-based knowledge. Additionally, the EMS-C program supports the infrastructure of the Pediatric Emergency Care Applied Research Network to conduct rigorous multi-site clinical trials. Pilot research studies in the field of pediatric emergency care are supported through the Targeted Issue grants.

In order to achieve system improvements across the Federal system, the EMS-C Program has synergistic collaborations with other Federal agencies. With the Department of Transportation's National Highway Traffic Safety Administration's Office of Emergency Medical Services (OEMS), EMS-C is a partner in the implementation of the National EMS Information System. EMS-C partners with OEMS to ensure pediatric relevant issues are integrated into EMS policy, education and guidelines. With the Indian Health Service (IHS), EMS-C assures the availability of pediatric-specific training initiatives tailored to the needs of tribal EMS and IHS medical facility professionals. In addition, the EMS-C Program utilizes the Agency for Health Care Research and Quality (AHRQ) to provide national data on childhood mortality secondary to injury and referral patterns of pediatric patients among various designations of Trauma Centers.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbooks, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$21,454,000
FY 2011	$21,369,000
FY 2012	$21,116,000
FY 2013	$21,460,000
FY 2014	$21,116,000

Budget Request

The FY 2014 Budget Request is $21,116,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. This request supports the program's efforts to achieve its FY 2014 performance targets. This includes improvement in the pediatric emergency infrastructure such as the assurance of life saving pediatric equipment on ambulances and the development of pediatric hospital recognition systems.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
14.V.B.2.A: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of BLS providers. *(Output)*	FY 2011: 43 Target: 41 (Target Exceeded)	41	44	+3
14.V.B.2.B: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of ALS providers. *(Output)*	FY 2011: 45 Target: 41 (Target Exceeded)	41	46	+5
14.1.A: Percent reduction in mortality rate for children with an injury severity score greater than 15. *(Outcome)*[144]	FY 2005-2009 Average Annual 0.5% reduction[145] FY 2009: 5.72% (Baseline)	0.5% reduction from prior year	0.5% reduction from prior year	Maintain
14.V.B.3A: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on BLS ambulances. *(Output)*	FY 2010 Result: 2 Target: 1 (Target Exceeded)	N/A	N/A[146]	N/A

[144] The new data source for this measure is the National Emergency Department Sample (NEDS). Data is reported from the most currently available pediatric mortality data. Source: Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality.

[145] An average percentage reduction was derived over a 5 year period (2005-2009). The annual percent reduction is calculated by the difference in mortality rate from the previous year divided by the base year rate, the reference Mortality Rate for FY 2009 is 5.72%.

[146] Data on measures (14.V.B.3A & B) is only collected every three years. N/A is listed for non-data collection years. The next data collection cycle is in 2013 and will be reported in FY 2014.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
14.V.B.3B: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on ALS ambulances. *(Output)*	FY 2010 Result: 2 Target: 1 (Target Exceeded)	N/A	N/A	N/A
14.V.B.4A: Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies. *(Output)*	FY 2011 Result: 24 Target: 14 (Target Exceeded)	15	25	+10
14.V.B.4B: Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies. *(Output)*	FY 2011 Result: 48 Target: 45 (Target Exceeded)	45	49	+4

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	77	79	79
Average Award	$244,000	$236,000	$236,000
Range of Awards	$122,501 – 2,800,000	$40,000 – $2,800,000	$40,000 – $2,800,000

Healthy Start

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$103,532,000	$105,218,000	$103,532,000	---
FTE	5	5	5	---

Authorizing Legislation - Section 330H of the Public Health Service Act.

FY 2014 Authorization .....Expired

Allocation Method .....Competitive grant/co-operative agreement

Program Description and Accomplishments

The Children's Health Act of 2000 (P. L. 106-310) amended the Public Health Service Act to provide "such sums as necessary" for continuation and expansion of a distinct Healthy Start program of grants that use community-designed and evidence-supported strategies aimed at reducing infant mortality and improving perinatal outcomes in project areas with high annual rates of infant mortality.

Through a lifespan approach and a focus on the interconception health of women, the Healthy Start program (HS) aims to reduce disparities in access to and utilization of health services, improve the quality of the local health care system, empower women and their families, and increase consumer and community voices and participation in health care decisions. Through grants to communities with exceptionally high rates of infant mortality (at least 1½ times the U.S. national average), HS continues to focus on the contributing factors that research shows are associated with poor perinatal outcomes, particularly among non-Hispanic Black and other disproportionately affected populations. In these geographically, racially, ethnically, and linguistically diverse low income communities, HS provides intensive services tailored to the needs of high risk pregnant women, infants, mothers, and fathers.

Adverse Pregnancy Outcomes in United States

Each year in the United States, more than four million women become pregnant, according to data from National Center for Health Statistics. This resulted in 4.13 million live births in 2009, a three percent decrease from 2008. In comparison, in 2007 there were 4.3 million live births, a one percent increase in births from 2006 and the highest number of births ever registered in the United States.[147] While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist in the proportion of pregnancy-related maternal deaths, in preterm births, and in infant mortality.

[147] Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2009. National Vital Statistics Reports Web release; vol. 59 no. 3. Hyattsville, MD: National Center for Health Statistics. 2010.

Preterm birth (births at less than 37 completed weeks of gestation) is a key risk factor for infant death. Since the mid-1980s, the percentage of preterm births in the U.S. has been rapidly increasing. For example, from 2000 to 2005, the percentage of preterm births increased from 11.6 percent to 12.7 percent representing an almost one percent increase. In 2005, 68.6 percent of all infant deaths occurred to preterm infants, up from 65.6 percent in 2000.[148] The 2009 overall national preterm rate was 12.18 percent. Although a portion of the increase in preterm births over the last decade was due to an increase in multiple births, the percentage of preterm births also increased among singleton births.

Racial Disparities in Pregnancy Outcomes

There are significant racial disparities in preterm births and infant death rates in the U.S. For example, in 2005 the preterm birth rate for non-Hispanic White infants was 10.92 percent compared to 17.47 percent for non-Hispanic Black infants. Similarly, the preterm-related infant mortality rate for non-Hispanic Black infants was 3.4 times higher than that of non-Hispanic White infants.[149] Despite considerable research efforts to understand and prevent these adverse outcomes, the factors that make some pregnancies more vulnerable than others have not been clearly identified or defined. Emerging research indicates that environmental, biological and behavioral stressors occurring over the lifespan of the mother from her earliest life experiences until she delivers her own child may account for a significant portion of the disparities. These social determinants of health may hold the key to reducing infant mortality. Moreover, it may take specific interventions that are consistently provided over several generations to reduce and eliminate the factors responsible for the disparities in adverse birth outcomes.

Interconception Healthcare

The interconception period (the time between the end of a woman's pregnancy to the beginning of her next pregnancy) is a critical time to modify risk factors, particularly those such as tobacco use, that are causally associated with infant mortality. Interconception healthcare may improve complications from a recent pregnancy and/or prevent the development of a new health problem (obesity, diabetes, depression, and hypertension) in both the woman and her children. A leading risk factor of a future poor birth outcome is a previous poor birth outcome. Therefore, a focus on interconception care is a hallmark of HS. Additionally, interconception healthcare provides a valuable opportunity to reduce or eliminate risks before one or more future pregnancies to ensure healthier (full term) infants and mothers.

Healthy Start-Community Collaborations to Address Pregnancy Outcomes

HS works with individual communities to build upon their existing resources (including outreach, health education, case management, and utilization of prenatal/postnatal care) to improve the quality of, and access to, healthcare for women and infants at both service and system levels through the implementation of innovative community-driven and community-

[148] MacDorman MF, Mathews TJ. Recent Trends in Infant Mortality in the United States. NCHS Data Brief, no 9. Hyattsville, MD: National Center for Health Statistics. 2008.
[149] National Center for Health Statistics, Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data set, NVSR, vol. 57 no. 2, revised July, 2008.

based interventions. At the service level, beginning with direct outreach by community health workers to women at high risk, Healthy Start projects ensure that the mothers and infants have ongoing sources of primary and preventive healthcare and that their basic needs (housing, psychosocial, nutritional and educational support and job skill building) are addressed. Following assessments and screening for perinatal depression and other risk factors, case managers provide linkages with appropriate services and health education for risk reduction and prevention. Mothers and infants are linked to a medical home and followed, at a minimum, from entry into prenatal care through two years after delivery.

At the system level, every Healthy Start project has developed a consortium composed of neighborhood residents, community key leaders, perinatal care clients or consumers, medical and social service providers, as well as faith-based and business community representatives. Together these key stakeholders and change agents address the system barriers in their community, such as fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care. Healthy Start projects are required to have strong collaborative linkages with State programs including Title V Maternal and Child Health Block Grant, Medicaid, Children's Health Insurance Program, and local perinatal systems such as those in community health centers. The close connection between these services assists in reducing significant risk factors, such as tobacco and alcohol use, while promoting behaviors that can lead to healthy outcomes for women and their families. These positive relationships and effects, beginning during the perinatal period, continue to be monitored for both mother and baby for two years post-delivery to ensure that they remain linked to ongoing sources of primary care. Knowing the importance of a healthy family and healthy home, as appropriate, the needs of the entire family are addressed.

Populations Served by Healthy Start

There are currently 104 Healthy Start projects serving populations within 179 counties in 39 States, the District of Columbia, and Puerto Rico. Many of these communities have large poverty and major crime. Parents at highest risk typically have less than a high school education, are low income and have limited access to safe housing. Medical healthcare providers are limited and often can only be reached after long commutes on crowded public transportation.

Selected Healthy Start Successes

Genesee County Michigan Healthy Start serves a predominantly African American population. In the target area there is 41 percent unemployment for those 16 years and older. Families in the Healthy Start project area continue to fare worse than their counterparts in Genesee County and significantly worse than others in Michigan. The Healthy Start project area has fewer high school graduates compared to the rest of the county. For example, only 76 percent of those 25 and older graduated from high school which is below the figure of 83.4 percent for the State of Michigan and 83.1 percent for the entirety of Genesee County. Currently, 20 percent of the target area population lives below the Federal Poverty Level. The household income in the project area is $29,982 which is considerably lower than the County and the State. In 2001, the Genesee County Health Department in Flint, Michigan became the lead agency for the Genesee County Healthy Start project and, even with the challenges described

above, has since proven to be effective in reducing infant mortality rates and low birth weight (LBW) rates among program participants. The infant mortality rate for the project years 2001-2007 has averaged 2.7 per 1,000 live births, well below the Healthy People 2020 Objective of 6.0 per 1,000 live births. For the years 2001-2007, the LBW rate averaged 14.1 percent, and the very low birth (VLBW) weight rate averaged 2.3 percent. Additionally, low and VLBW rates have remained on a downward trend. For 2004-2009, for HS participants in Genesee County there were a total of 952 births (including twins) and 932 births (excluding twins). Of the 932 singleton births, the LBW rate averaged 10.5 percent and the VLBW rate averaged 9.65 percent. Of all births, including twins, the infant mortality rate averaged 4.2 per 1,000 live births during the same period of time. The LBW rate has remained on a downward trend with a three year (2007-2009) average of 8.84 percent.

The Strong Beginnings Healthy Start Project in Grand Rapids, Michigan serves predominantly (94%) high risk African American (AA) women. In 2010, Grand Rapids had an unemployment rate of 30.6% for AAs and 11.2% for Whites. The target population is within an area of concentrated poverty with a poverty level of 43.7% for children younger than 18. The poverty rate for AA children is twice that of White children, at 73.4% versus 35.8% in 2010. Infant mortality, low birth weight and very low birth weight rates were high on a three year average among AA from 2007 -2009 at 17.3, 13.6 and 3.3 per 1000, respectively. The infant mortality rate for AAs were nearly four times higher than for White infants at 4.4 per 1000. Also, women in the Healthy Start program were more likely to be diagnosed with clinical depression, domestic violence, substance abuse and homeless and unwanted pregnancy.

The Strong Beginnings Healthy Start Project has demonstrated the ability to engage women in services and proven to be effective in reducing infant mortality and low birth weight rates among program participants. The Infant mortality rate for program participants is 8.3 per 1000 versus 16.7 per 1000 for AA women in Grand Rapids, and this is down from 22.4 per 1000 in 2003. The low birth weight rate for program participants was 5.6% from 2011 -2012 vs. 14% for AA women in Grand Rapids. Also, the very low birth rate for participants was 0% vs. 4% for AA women in Grand Rapids. Further analysis shows that 96% of women and 99% of children had a medical home; 92% of infants had seven or more well-child visits. There were only 9% of participants who were pregnant again within 18 months of delivery compared to 27% of AA women in Grand Rapids who had a subsequent pregnancy within 18 months, which is down from 34% in 2007. Though there is a downward trend in regards to infant mortality, low birth weight and very low birth weight rates, there is still work to be done.

The South Carolina Low Country Healthy Start Project serves high risk populations in Allendale, Bamberg, Hampton and Orangeburg Counties. In 2011, the SC Low Country Healthy Start program provided case management services for 366 pregnant women, 368 post-partum women and 647 infants. There were no infant deaths for program participants enrolled in the South Carolina Low Country Healthy Start program in 2010 and 2011.

The percent of SC Low Country Healthy Start program participants delivering a low birth weight infant was reduced from 15.8% in 2010 to 13.1% in 2011. The very low birth weight percent fell from 6.3% to 3.7% for all live births. When singleton births only are considered, the data

showed low birth weight infants was reduced from 13.8% in 2010 to 9.8% in 2011 and for singleton very low birth weight births the percent dropped from 4.7% in 2010 to 2.8% in 2011.

Further analysis showed, in 2011, the percent of SC Low Country Healthy Start program participants receiving prenatal care in the first trimester increased from 83% in 2010 to 86% in 2011.

Reduction in Infant Deaths in Healthy Start Project Areas

There are achievements linked to HS in other communities as well, most significantly, a decrease in the number of infant deaths of Healthy Start participants. In fact, thirteen Healthy Start communities report no infant deaths among program participants for the three years 2007-2009: Mississippi County, AR; Maricopa County, AZ; Mary's Center, Washington, DC; Honolulu, HI; Chicago, IL; Tougaloo, MS; all three HS sites in Raleigh, NC; Pembroke, NC; Las Cruces, NM; Portland, OR; and Philadelphia, PA; an additional ten communities reported no infant deaths over the two years 2008-2009: Mobile, AL; Fresno, CA; Washington, DC; Pennsauken, NJ; Memphis, TN; Atlanta, GA; Wichita, KS; New Orleans, LA; Boston, MA; and Pennsauken, NJ.

Among African Americans in 2007, the infant mortality rate for the HS program participants in *Saginaw County's (MI) Great Beginnings Healthy Start* was only 5.8 per 1,000 live births. In the *Jacksonville (FL) Healthy Start*, a program that focuses on high risk interconceptional women and which also serves a predominantly African American population, the infant mortality rate was reported at 15.6 per 1,000 live births in 2001, 14.0 per 1,000 live births in 2005 and no infant deaths in 2009. The infant mortality rate for the northern Wisconsin tribes served by the *Great Lakes Intertribal Councils Honoring Our Children Project* for 2007 was 17.1 per 1,000 live births; in contrast, the infant mortality rate was only 6 per 1,000 live births among program participants for 2009 (see Outcomes and Outputs tables).

Overall, Healthy Start is successful in reducing infant mortality in the Nation's highest risk populations for adverse outcomes (African Americans, American Indians/Native Americans). In contrast to the total national infant mortality rate of 6.42 in 2009, the infant mortality rate for Healthy Start participants was 6.0 infant deaths per 1,000 live births for 2009 – remembering that HS serves the highest risk women in some of the highest risk communities.

Low and Very Low Birthweight

LBW, or birth weight less than 2,500 grams, is a major contributor to infant mortality and has been dramatically reduced among Healthy Start participants. The national LBW rate increased more than 20 percent from the mid 1980s through 2006 but has recently shown a slight decrease. In 2009, the national LBW rate was 8.16% which was a slight decrease from the 2008 rate of 8.18 percent. However, racial disparities persist in LBW rates. For example, in 2009, the LBW rate among non-Hispanic white was 7.19 percent compared to 13.61 percent for non-Hispanic Black infants. Similarly, in 2009, the VLBW or birth weight of less than 1,500 grams was 1.16 percent for non-Hispanic White infants compared to 3.06 percent for non-Hispanic Black infants. In 1998, the National LBW was 7.6 percent, and 65 percent of all infant deaths were attributed to LBW (Source: NVSS, NC). The *Mississippi County Arkansas EOC, Inc* in Blytheville, AR,

improved its LBW rate from a high of 12.5 percent in 2006 to 0 percent in 2009. *Baltimore Healthy Start* decreased its LBW rate from 13.2 percent in 2006 to 4.9 percent in 2009. The percent of African American babies born VLBW in Baltimore is currently 1.5 percent which is approaching that of non-Hispanic White babies citywide. In the *Pittsburgh (PA) Healthy Start, Inc.* project, the percent of VLBW live births decreased between 2005 and 2008 from 2.9 percent to 1.7 percent. In addition, among the *Pittsburgh Healthy Start, Inc.* participants, the VLBW rate is similar to the VLBW for the entire community which was 1.76 percent in 2009. *Kalamazoo (MI) Healthy Baby Healthy Start* has reduced the racial disparity in prematurity to the point that non-Hispanic Black Healthy Start participants have pregnancies that are as healthy (i.e., full term and normal weight) as their non-Hispanic neighbors.

Increasing Prenatal Care

An important risk factor for infant mortality is late entry into prenatal care. In 2004, the national mortality rate for infants of mothers who began prenatal care after the first trimester of pregnancy or not at all was 8.35 per 1,000. This rate was 37 percent higher than the rate for infants of mothers who began care in the first trimester (NVSS, NCHS, 2007). The population served by the Healthy Start projects are by definition disadvantaged and high risk. The proportion of Healthy Start clients receiving early prenatal care is very low. While nationally, 82.8 percent of pregnant women received prenatal care in the first trimester in 1998, first trimester entry into prenatal care for Healthy Start projects participants was only 41.8 percent. The reason for this low early prenatal care utilization, however, is not lack of insurance coverage since most Healthy Start clients are Medicaid eligible, and thus additional coverage through the ACA will have little effect on early prenatal care utilization for the Healthy Start population. Through outreach, health education and care coordination, Healthy Start grantees have played an important role in connecting their clients to services and improving access to and the utilization of prenatal care services for members of the communities served by their programs. Healthy Start grantees have extensive experience as health care navigators and have successfully connected their clients to services, resulting in an increase in the proportion of women receiving early prenatal care. For example, from 1998 to 2007, the Healthy Start projects had increased first trimester early-entry into prenatal care (EPNC entry) of their population from 41.8% to 68.5 percent and in 2009, EPNC climbed to 70.9 percent. Between 2006 and 2008, several Healthy Start projects more than doubled their EPNC rate including: the *City of New Orleans Healthy Start* project whose EPNC rate increased from 23.6 percent to 72.3 percent; the *Maricopa Department of Health, Tempe, AZ Healthy Start Project* whose EPNC rate increased from 32.1 percent to 71 percent in 2009; and the *Family Road of Greater Baton Rouge (LA) Inc* increased from 56.6 percent in 2006 to 77 percent in 2009. The *Laurens County Heart of Georgia Healthy Start Initiative* increased first trimester entry among its participants from 21.6 percent in 2003 to 91.5 percent in 2009.

Addressing Barriers to Healthcare Access

Because of Medicaid coverage, medical insurance is usually not a barrier for receiving care during pregnancy through 60 days following delivery and Healthy Start projects have been able to connect women and children who are eligible for Medicaid with health care service providers. During a recent project period (FYs 2001 - 2005), 74 percent of the pregnant women enrolled in

Healthy Start had no health insurance at the time of enrollment. Healthy Start staff completed Medicaid or CHIP applications on all uninsured Healthy Start participants. In total, 969 (98%) of 991 Medicaid/CHIP applications submitted by Healthy Start were approved for Medicaid or CHIP coverage. By reducing a significant barrier to utilizing appropriate healthcare, Healthy Start projects have made important strides in helping at-risk mothers have healthy babies and families.

However, lack of medical insurance has been identified as a major barrier for receiving care outside of pregnancy. Affordable Care Act health insurance expansions scheduled to begin in 2014 will help address this issue by extending coverage to mothers who previously lacked coverage during the interconception care component of Healthy Start, particularly in states that expand Medicaid to 133% of poverty. Healthy Start will continue to play a critical role in providing case management and care coordination services that enable women to access health care services essential to improving maternal and infant health outcomes. Increasing the inter pregnancy interval (the time between pregnancies) increases a woman's chances of having a better birth outcome with a subsequent pregnancy. This financial barrier to care is compounded by the extremely limited healthcare services for the under/uninsured in many Healthy Start project areas. Many providers of these groups are reluctant to see uninsured women and children. Healthy Start projects have been able to help women and children eligible for Medicaid. By providing insurance coverage to the Healthy Start population beyond current Medicaid pregnancy-related coverage, the ACA could play a major role in supporting the efforts of Healthy Start grantees to ensure that poor, uninsured and underinsured families receive the care they need.

Funding History

FY	Amount
FY 2010	$104,776,000
FY 2011	$104,361,000
FY 2012	$103,532,000
FY 2013	$105,218,000
FY 2014	$103,532,000

Budget Request

The FY 2014 Budget Request is $103,532,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. The requested funding will continue to support 104 Healthy Start sites. Approximately 78 will be competing renewals for community based projects and approximately 26 will be non-competing continuation grants. Thirty-nine States, the District of Columbia and Puerto Rico will continue to have Healthy Start services. Approximately 466,259 participants will continue to receive services. Healthy Start sites employ an average of 20 persons per grant and thus are significant employers in the high-risk communities they serve. Under the amount requested, funded programs will collectively employ approximately 2,100.

The proposed FY 2014 Budget Request will allow HRSA to continue to build on the successes and lessons learned over the past 20 years of Healthy Start. Through outreach, care coordination and health education, Healthy Start grantees will play a role in implementing the ACA by ensuring that their clients enroll in expanded health insurance coverage beginning in 2014, use clinical preventive services, and understand the ACA consumer protections. An enhanced Healthy Start will include designing activities and components that will support the Administration's priorities of building a ladder of opportunity for all children. Healthy Start will be the first rung of that ladder by working to reduce infant mortality and improve birth outcomes.

Healthy Start will begin before the child is born, in fact before the child is conceived, and include pre-conception and well-woman care. Parenting education before, during, and after the pregnancy is critical to a family's success. Furthermore, a healthy woman is more likely to have a positive birth outcome and healthy child. So Healthy Start will work to ensure women and families have a comprehensive medical home. And that these families are able to navigate through the healthcare system to receive integrated and coordinated care. Healthy Start will continue to build resilience in program participants and the communities being served.

Healthy Start will prepare families to continue their climb on the ladder of opportunity and success through ensuring a seamless handoff of a healthy infant to the next rungs of quality childcare, Home Visiting, Early Head Start, and preschool. The targets for performance measures 12.III.A.I and 12.III.A.2 are 75 percent and 9.6 percent, respectively.

All Healthy Start projects are committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care and improving the health of the young women and infants in their communities. To assist projects, Healthy Start will support peer mentoring, technical assistance, the Healthy Start Leadership Training Institute, webcasts, site visits and sharing of best practices among projects.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
12.1: The infant mortality rate (IMR) per 1,000 live births among Healthy Start Program clients.[150] *(Outcome)* (Baseline- 2004: 7.65 per 1000 live births)	FY 2009: 6 per 1,000 live births. (Target Not in Place)	N/A	N/A	N/A

[150] This long-term measure does not have annual targets. FY 2013 is a long-term target year.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
12.III.A.1: Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2010: 74% Target: 75% (Target Not Met but Improved)	75%	75%	Maintain
12.III.A.2: Percent of singleton births weighing less than 2,500 grams (low birth weight) *(Outcome)*	FY 2010: 10% Target: 9.6% (Target Not Met but Improved)	9.6%	9.6%	Maintain
12.E: Increase the number of persons served by the Healthy Start Program with a (relatively) constant level of funding. *(Efficiency)*	FY 2010: 445,259 Persons Served ($227/Participant) Target: 524,500 (Target Not Met)	532,500	466,259	-66,241

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	109	104	104
Average Award	$750,000	$750,000	$750,000
Range of Awards	$133,000 - $2,350,000	$255,000 - $2,350,000	$255,000 - $2,350,000

Heritable Disorders Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$9,834,000	$9,994,000	---	-$9,834,000
Prevention Fund	---	---	$9,834,000	+$9,834,000
Total	$9,834,000	$9,994,000	$9,834,000	---
FTE	4	4	4	---

Authorizing Legislation - Sections 1109 – 1112 & 1114 of the Public Health Service Act.
Authorization: 1109 .....……...…….Expired
Authorization: 1110 ……...…….……...….....Expired
Authorization: 1111 .....……...…Expired
Authorization: 1112 .....……...…Expired
Authorization: 1114… .....……...…Expired

Allocation Methods……..……Contract/Competitive grant/Co-operative agreement

Program Description and Accomplishments

- The programs and activities under this Act are established to enhance, improve or expand the ability of States and local public health agencies to provide screening counseling or health care services to newborns and children having or at risk for heritable disorders. Newborn and child screening occur at intervals across the life span of every child. Universal newborn screening provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions. It is expected that newborn and child screening will expand as the capacity to screen for genetic and congenital conditions increases

    - Improved Newborn and Child Screening For Heritable Disorders, Section 1109

The purpose of the Critical Congenital Heart Disease (CCHD) Newborn Screening Demonstration Program is to support the development, dissemination and validation of screening protocols and newborn screening infrastructure needs for point of care screening specific to CCHD. The CCHD program focuses on enhancing State screening infrastructure, including the implementation of electronic health information exchanges for collecting and reporting pertinent data from hospitals, as well as the education and training of various stakeholders on testing methodology and follow-up protocols.

The CCHD Demonstration Project established in FY 2012:

1. Enhances, improves or expands the capacity of State and local public health agencies and hospitals to: provide screening, counseling, link the results of CCHD screening to needed follow-up health care services, and/or perform the necessary quality assurance, outcomes analysis and other public health surveillance functions;
2. Assists in providing health care professionals and newborn screening program personnel with education in newborn screening and training in relevant new technologies for critical congenital heart disease (such as the use of pulse oximetry);
3. Develops and delivers educational programs (at appropriate literacy levels) about critical congenital heart disease newborn screening, counseling, testing, follow-up, treatment, and specialty services to parents, families, and patient advocacy and support groups; and
4. Establishes, maintains, and operates a system to coordinate and assess screening programs and follow-up relating to critical congenital heart disease.

The integrating NBS long term follow-up into primary care initiative was first funded in 2013. Three grantees are funded to link to a number of Community Health Centers to support the follow-up of individuals identified by NBS to have a heritable condition. The Program funds grantees working with primary care practices to identify the NBS population followed by their clinics and answer the following questions: 1) How many people seen by the center have a NBS condition; 2) Does each patient have a care plan based on best practices; and 3) Do all the patients with NBS conditions have the opportunity to enroll in research related to their disorder or similar issues developed in the manuscript below.

- Evaluating the Effectiveness of Newborn and Child Screening (NBS) Programs, Section 1110

The grant program, including seven Regional Genetic Service Collaboratives (RCs) and a National Coordinating center, was established in 2004 to support the Heritable Disorders Program and was awarded in 2012 for a third cycle of funding. The Collaboratives continue to under-take a regional, collaborative approach to address the misdistribution of genetic resources and services, the quality of services, and the problems families and primary health care providers have in accessing and utilizing those services. Collaborative projects focus on the life course of the individuals affected with or at risk of heritable disorders and their families. Special emphasis is given to medically underinsured and rural populations with attention to cultural sensitivity.

The Collaboratives include all States, U.S. Territories, and the District of Columbia. The stakeholders represent State public health professionals, genetics specialists, primary care providers, consumers, and the public. The Collaborative projects utilize long distance education and clinical strategies (telemedicine), advanced newborn screening technologies, integrated education and training tools, health information technology, and just–in-time resource. In line with HRSA's priority, an important new project activity is the attention to the Affordable Care Act (ACA) and State health benefit exchanges. Moreover, the National

Coordinating Center is leading a comprehensive Evaluation Program - regional, multi-regional and national, to demonstrate the impact of activities to improve health outcomes.

- The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Act, if reauthorized, the Committee will continue to: 1) provide advice, technical information and systematic evidence-based and peer-reviewed recommendations to the Secretary to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders; 2) refine the model decision-matrix for newborn screening expansion; 3) address the public health impact of newborn screening expansion; 4) periodically update the Recommended Uniform Screening Panel (RUSP), as appropriate, based on the decision-matrix; and 5) consider ways to ensure that all States attain the capacity to screen for conditions on the RUSP.

In February 2008, the Committee finalized its nomination and evidence review process for conditions to be considered for addition to the recommended uniform screening panel. In 2012, the decision matrix was expanded to include a process for evaluation of the public health impact for addition of disorders to the RUSP.

On May 21, 2010, the Secretary adopted the Committee's recommendations to adopt the Committee's Recommended Uniform Screening Panel as a national standard for newborn screening programs and to facilitate the adoption of the Committee's Recommended Uniform Screening Panel by all State newborn screening programs.

- The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse is a central repository of current educational and family support and services information, materials, resources and research, for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn disease and screening services; and 3) links to current quality indicators data on newborn screening performance. It will be re-competed in FY 2014.

- Newborn Screening Data Repository and Technical Assistance Center

The newest competition and award for an updated information system was awarded in 2012. The data repository supports a data collection mechanism for quality indicators information related to newborn screening performance by the States, such as false-positive rates and other measures important in assessing newborn screening as determined by the States and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. The data repository will also standardize, maintain, and analyze quality indicators for State Newborn Screening programs in order to assist with the evaluation of the impact of State and territorial newborn screening programs and support short term monitoring of children with congenital conditions identified by newborn screening. Technical assistance will also be provided to

newborn screening stakeholders to support activities such as: 1) a system for continuous quality enhancement related to the newborn screening system, from birth to confirmation; 2) maintenance of a newborn screening program expert team for site visits; and 3) development of a certification program for newborn screening programs that meet the quality enhancement measures.

- The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The Act specifies that the ICC be composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. Other federal agencies have liaisons on the committee as well. The ICC was delegated to HRSA and CDC to serve as co-chairs on March 2, 2011. Per the legislation, the ICC serves to: 1) assess existing activities and infrastructure in order to make recommendations for programs to collect, analyze and make data available on the heritable disorders recommended by the Committee; and 2) make recommendations for the establishment of regional centers for the conduct of applied epidemiological research on effective interventions to promote the prevention of poor health outcomes resulting from such disorders, as well as provide information and education to the public on such effective interventions. The ICC also serves to coordinate collaborative efforts for newborn and child screening among all agencies in HHS and serves to identify policy issues requiring attention by Federal agencies.

Activities to date include responding to Secretarial requests to provide input regarding recommendations from the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children concerning: newborn screening for critical congenital heart disease, the use and storage of newborn screening residual blood samples and data quality assurance in newborn screening.

Funding History

FY	Amount
FY 2010	$9,992,000
FY 2011	$9,952,000
FY 2012	$9,834,000
FY 2013	$9,994,000
FY 2014	$9,834,000

Budget Request

The FY 2014 Budget Request is $9,834,000. The FY 2014 Request is the same as the FY 2012 Enacted Level. The FY 2014 Budget funds this program through the Prevention and Public Health Fund (PPHF).

Improved Newborn and Child Screening For Heritable Disorders, Section 1109

Demonstration Project for State Newborn Screening-Critical Congenital Heart Disease Newborn Screening - Continued funding will allow for completion of the grant cycle at a similar level of projects and funding. This will provide for the development of screening systems in ten States and the dissemination of best practices and technical assistance to other States considering the addition of CCHD to their State NBS panel. Funding will also allow grantees to establish, maintain, and operate a health information technology system that will collect information on the detection of CCHD and patient outcomes and utilize the data to assess and coordinate.

Integrating NBS long term follow-up into primary care - FY 2014 is year two of three of the Program. Continued stable funding will allow for continued integration and evaluation of newborn screening long term follow-up practices into Community Health Centers.

Evaluating the Effectiveness of Newborn and Child Screening Programs, Section 1110

Regional Genetic and Newborn Screening Services Collaborative - The Regional Collaborative Program began its third cycle in 2012 [2017]. With stable funding the Regional Collaborative will continue to provide the services and projects outlined to complete their third grant cycle. As health care reform matures, and as its capacity to personalize health care is realized, the integration of genetic medicine into the health care delivery system is essential.

The Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Act, if reauthorized, the Committee will continue to: 1) provide advice, technical information and systematic evidence-based and peer-reviewed recommendations to the Secretary to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders; 2) refine the model decision-matrix for newborn screening expansion; 3) address the public health impact of newborn screening expansion; 4) periodically update the Recommended Uniform Screening Panel (RUSP), as appropriate, based on the decision-matrix; and 5) consider ways to ensure that all States attain the capacity to screen for conditions on the RUSP. The Act also requires the Committee to address other legislative requirements toward facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs.

The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse will be re-competed in FY 2014. Continued stable funding will allow for ongoing support of a central repository of current educational and family support and services information, materials, resources and research for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn disease and screening services; and 3) link with the public site of the Newborn Screening Data Repository

and Technical Assistance Center which maintains current data on quality indicators of newborn screening performance.

Newborn Screening Data Repository and Technical Assistance Center - The Technical Assistance Center is in year three of five for FY 2014. With stable funding, the Center will continue to provide technical assistance and programmatic support for the State public health programs, particularly as new conditions for newborn screening are considered and implemented throughout the U.S. The continued Quality Enhancement Program will be able to continue to function and work to insure the quality of the State newborn screening programs that includes all portions of the public health program, including short term follow-up.

The Act also requires the Committee to address other legislative requirements toward facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs. For example, at this time there is no consensus on diagnostic criteria, so calculations of incidence and prevalence of disorders are inaccurate. There are no established criteria for acceptable screening rates nor an ability to calculate how many infants are unscreened each year. The development of quality measures requires a process for input from multiple stakeholder groups, which requires expertise, staff time and logistics and will be accomplished with this resource. The data repository with continued support will be able to continue to collect the critical data needed for evaluation and quality assessment of newborn screening across the US. With continued financial support the Center will continue to interface at multiple levels with various other HRSA funded programs, including but not limited to the Clearinghouse for Newborn Screening Information as required by the authorizing legislation.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The ICC will continue to undertake relevant activities including: 1) activities and infrastructure, in order to make recommendations for programs to collect, analyze, and make data available on the heritable disorders recommended by the Committee; and 2) make recommendations for the establishment of regional centers for the conduct of applied epidemiological research on effective interventions to promote the prevention of poor health outcomes resulting from such disorders, as well as provide information and education to the public on such effective interventions. The ICC also serves to coordinate collaborative efforts for newborn and child screening among all agencies in HHS and serve to identify policy issues requiring attention by federal agencies. The Act specifies that the ICC be composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. CMS and ASPE staff serve as liaisons to the ICC.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	16	18	18
Average Award	$484,000	$430,000	$430,000
Range of Awards	$300,000 – $700,000	$250,000 – $650,000	$250,000-$650,000

Family-To-Family Health Information Centers

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$5,000,000	$5,000,000	---	-$5,000,000
FTE	1	1	---	-1

Authorizing Legislation - Section 501(c)(1)(A) of the Social Security Act.

FY 2014 Authorization .....Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program is authorized to fund family-staffed/run centers that provide information, education, technical assistance and peer support to families of children and youth with special health care needs (CSHCN). This program accomplishes this intent by assisting families and professionals so that "families with CSHCN will partner in decision making at all levels" of health care decision making.

Currently, the program is funded through FY 2013 by the American Taxpayer Relief Act of 2012 (P.L. 112-240), Sec. 624 at a funding level of 5 million dollars. Previous appropriations include the Deficit Reduction Act of 2005 (P.L. 109-171) and Section 5507(b) of the Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) which extended the program through FY 2012.

The Program for FYs 2010-2013 supported centers in 50 States and the District of Columbia to: (1) assist families of CSHCN to make informed choices about healthcare in order to promote good treatment decisions, cost effectiveness and improved health outcomes; (2) provide information regarding the healthcare needs of and resources available for CSHCN; (3) identify successful health delivery models; (4) develop, with representatives of healthcare providers, managed care organizations, healthcare purchasers, and appropriate State agencies, a model for collaboration between families of CSHCN and health professionals; (5) provide training and guidance regarding the care of CSHCN; (6) conduct outreach activities to families, health professionals, schools and other appropriate entities; and (7) be staffed by such families who have expertise in Federal and State public and private healthcare systems; and by health professionals.

Currently, 51 centers are collecting data on the issues facing families regarding services and financing of those services while working with Medicaid, Education, Title V, and other agencies to inform them of families' needs. Centers are also disseminating information on the implementation of ACA and encouraging family leaders to be involved in the planning within their states such as planning for health insurance Marketplaces and Navigator Programs. Other

information disseminated through fact sheets, newsletters and listservs are helping families understand the new provisions and how they impact individual access to coverage, such as the extension of Federal dependent coverage to age 26. In addition, many are working with the Bureau of Primary Health Care's Federally Qualified Health Centers to implement medical/health homes through training and providing materials. Some of the centers are also working with the Administration on Aging's *Aging and Disability Resource Center*s on the "no wrong door" approach for sharing resource information across the lifespan for people with disabilities.

Program works with grantees, in collaboration with the National Center for Family/Professional Partnerships, on monthly technical assistance calls to enhance program content and data collection, including impact data.

In FY 2008, 75,532 families with CSHCN were provided information, education and/or training from Family-to-Family Health Information Centers. In FY 2009 more than 92,000 families were provided information. These exceeded the targets set for those years. In addition, for FY 2009, 65 percent of families responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making with their child's provider), exceeding the target. In FY 2010, no targets were set due to the fact that the program funding was scheduled to end. But the number of families served was 121,476.

In FY 2011, 146,813 families were provided information (one-on-one assistance, unduplicated count) by 50 centers and approximately 86 percent of families served responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making at any level, exceeding the target for that year. The number of families served in FY 2012 increased to 147,280 with 94% of those served stating the F2F HIC was useful in helping families be better partners in decision-making, again exceeding the annual target. Overall, since the program's inception, the F2F HICs program has realized a 51% increase in the number of families served and an increase of over 34 percentage points in the proportion of families served who report a positive outcome (as of FY 2012).

Funding also is obligated for costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System and HRSA's Electronic Handbooks, and follow-up performance reviews.

Funding History

FY	Amount
FY 2010	$5,000,000
FY 2011	$5,000,000
FY 2012	$5,000,000
FY 2013	$5,000,000
FY 2014	---

Budget Request

The authorization for this program expires at the end of FY 2013, and additional fund are not requested. Instead, families with Children with Special Health Care Needs can seek supports and wrap around services through state grants provided by the Maternal and Child Health Block Grant.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
15.III.C.1: Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (*Output)*	FY 2012: 147,280 Target: 123,000 (Target Exceeded)[151]	123,000	N/A	N/A
15.III.C.2: Proportion of families with CSHCN who received services from the Family-to-Family Health Information Centers reporting that they were better able to partner in decision making at any level. *(Outcome)*	FY 2012: 94% Target: 85% (Target Exceeded)[151]	85%	N/A	N/A

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards[152]	51	51	N/A
Average Award	$95,700	$95,700	N/A
Range of Awards	$95,700	$95,700	N/A

[151] These targets reflect Affordable Care Act funding.
[152] The number of actual base awards.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$350,000,000	$400,000,000	$400,000,000	+$50,000,000
FTE*	23	25	25	+2

- *Excludes 10 FTEs for ACF.

Authorizing Legislation - Section 511 of the Social Security Act.

FY 2014 Authorization $400,000,000

Allocation Methods:
- Direct federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program was established in FY 2010 under the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) to be collaboratively implemented by Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). The purpose of the MIECHV Program is: (1) strengthen and improve the programs and activities carried out under Title V; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

At-risk communities were identified through a statewide assessment of needs and existing resources to meet those needs. HRSA and ACF regard home visiting as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development as well as strong parent-child relationships. Both agencies envision evidence-based home visiting programs as part of a system for promoting health and well-being for pregnant women, children through age 5 and their families which includes a range of other services such as well-child health care, child care, Head Start, pre-kindergarten, special education, and the early elementary grades.

In FY 2012, there were 56 eligible entities for this program: forty-seven states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa; in addition, nonprofits were eligible to provide services in the states that relinquished funding: Florida, North Dakota and Wyoming. While most of the program funds are allocated to the state home visiting grants and general technical assistance, three percent is set aside for

grants available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations and three percent is set aside for Research, Evaluation, and Technical Assistance to state grantees.

The Program enables eligible entities to provide evidence-based home visiting programs to promote: maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; school readiness and achievement; reduction in crime or domestic violence; family economic self-sufficiency; and coordination and referrals for other community resources and supports.

This program requires participating states to utilize evidence-based home visiting models and provides an exciting opportunity for states and the Federal government to work together to deploy proven programs and to build upon the existing evidence base. The Program allows for continued experimentation with new home visiting models and evaluation of both new and existing approaches so that, over time, policymakers and practitioners will have more refined information about the approaches that work best, how different approaches work for different populations or targeted outcomes, and the relative costs and benefits of different models.

Grants to states are available to be administered by the lead state agency designated by the Governor to act on behalf of the state. American Indian grants can be awarded to an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in section 4 of the Indian Health Care Improvement Act.

In FY 2010, 56 state and territory formula grants and 13 American Indian grants were awarded. In FY 2011, 55 state and territory formula grants, 22 state and territory competitive grants, and 19 American Indian grants were awarded. In FY 2012, 53 state and territory formula grants; one grant (based on the state formula) to a non-profit organization to provide services in the state that relinquished funds (North Dakota); 16 new state and territory competitive grants in addition to 22 competitive continuation grants; and, seven new grants to American Indian Tribes (in addition to the 19 existing continuing American Indian grants).

In FY 2013, 53 state and territory formula grants, and two new grants (based on the state formula) to non-profit organizations to provide services in the states that relinquished funds (Florida and Wyoming) in addition to one continuing nonprofit award; 12 new state and territory competitive grants in addition to 25 competitive continuation grants; and 26 continuing American Indian grants.

Funding History

FY	Amount
FY 2010 ACA Funding	$100,000,000
FY 2011 ACA Funding	$250,000,000
FY 2012 ACA Funding	$350,000,000
FY 2013 ACA Funding	$400,000,000
FY 2014 ACA Funding	$400,000,000

Budget Request

The Affordable Care Act authorized and appropriated $400,000,000 for the Maternal, Infant, and Early Childhood Home Visiting Program for FY 2014, which is $50,000,000 above the FY 2012 Enacted Level. This level of funding will provide:

- $360 million for awards to 53 State and territory grantees and three non-profit organizations (56 grants by formula and approximately 31 competitive grants);
- $12 million for 24 to 26 awards to American Indian tribes; and
- $13 million for research, evaluation, and corrective action technical assistance for States not meeting benchmarks.

The funding allocated toward research and evaluation will specifically support activities such as the statutorily required national evaluation, a home visiting research network, investigator-initiated research grants, contracts to support review of models as evidence-based and a tribal early childhood research center.

Further, approximately $7 million supports technical assistance to grantees including contracts to continue providing technical support to States and territories on data systems, performance measurement, and quality improvement, to evaluate promising practices, to support a tribal resource center, and to enhance the efficiency and effectiveness of MIECHV programs through learning collaboratives and other activities. The remaining funds will be used for administrative costs.

Voluntary evidence-based home visiting services through the Maternal, Infant, and Early Childhood Home Visiting program are a critical element of the President's early learning initiative. These programs have been critical in improving maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills, children's cognitive, language, and social-emotional development, and school readiness. Home visits also can generate Medicaid savings through fewer preterm births and emergency room use. In addition, increasing numbers of home visiting programs, traditionally focused only on the mother–child relationship, are now expanding their efforts to engage fathers to promote improvements not only for the individual child's development, family safety, and the mother's continued engagement in home visiting services, but also for improving the self-sufficiency and parenting skills of the father himself.

The President proposes to extend and expand the home visiting program beginning in FY 2015 by providing a substantial new investment of $15 billion through FY 2023 to ensure that our most vulnerable Americans are on track from birth, and that later educational investments, including Early Head Start, high quality child care, and high quality preschool, rest upon a strong foundation.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
37.1: Number of home visits to families receiving services under the MIECHV program.[153] (*Output*)	State/Territory/Tribal: FY 2012: 161,712[154] (Target Not In Place)	State/Territory/Tribal: N/A	State/Territory/Tribal: 565,992	State/Territory/Tribal: N/A
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome-Developmental)*	N/A[155]	N/A	N/A	N/A

Grant Awards Tables
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	118[156]	119	113
Average Award	$2.71M	$3.13M	$3.29M
Range of Awards	$0.2M – $11.5M	$0.2M – $11.5M	$0.2M – $11.5M

[153] A home visit is the service provided by qualified professionals within the home to the enrolled caregiver and the index child. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the MIECHV program. The total number of enrollees and index children served during reporting period (as of February 8, 2013): State/Territory MIECHV: 19,206; Tribal MIECHV: 164. Enrollees: includes the person or persons in the household who signed up to participate in the home visiting program. Index child: the target child (birth – 5 years) in an individual household who is under the care of the enrollee(s).

[154] Information includes data for tribal MIECHV program. During FY 12, state MIECHV provided 161,012 home visits and tribal MIECHV provided 700 home visits.

[155] Data are anticipated to be available in FY 2014-2015 when states are required to report on benchmarks (i.e., after the end of the 3rd year of program operations).

[156] State formula grants were not awarded to Florida and Wyoming in FY 2012; grants anticipated to be awarded in FY 2013 to nonprofit organizations that will serve in those states.

Ryan White HIV/AIDS tab

Ryan White HIV/AIDS Treatment Extension Act of 2009 Overview

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$2,367,178,000	$2,336,479,000	$2,387,178,000	+$20,000,000
ADAP (non add)[157]	933,299,000	903,797,000	943,299,000	+10,000,000
MAI (non add)	160,722,000	169,077,000	161,026,000	+304,000
SPNS[158]	25,000,000	25,000,000	25,000,000	---
Total Funding	$2,392,178,000	$2,361,479,000	$2,412,178,000	+$20,000,000
FTE	141	141	141	---

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2012 and FY 2013 proposed for FY 2014.*

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2014 Authorization……...…...Expired

Allocation Method .....Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program, the largest Federal program focused exclusively on domestic HIV/AIDS care, provides services that are intended to 1) reduce the use of more costly inpatient care, 2) increase access to care for underserved populations, and 3) improve the quality of life for people living with HIV/AIDS (PLWH). The program works to achieve these aims by funding primary health care and support services that enhance access to and retention in care. The Ryan White HIV/AIDS Program funding pays for primary health care and treatment including referrals to specialty care and for support services that enhance access to and retention in care. The Ryan White HIV/AIDS Program fills gaps in care for PLWHA not covered by other resources or payers and serves as payer of last resort. The Program serves more than half a million low-income people with HIV/AIDS in the U.S. each year. Twenty-eight (27.6%) percent of those served by the Ryan White HIV/AIDS Program are uninsured and an additional 54% are underinsured.

In July 2010, the Administration released the first comprehensive *National HIV/AIDS Strategy (NHAS) for the United States*. The NHAS was the result of unprecedented public input,

[157] AIDS Drug Assistance Program (ADAP) Authorizing Legislation: Secs. 2611-31, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.
[158] Special Projects of National Significance (SPNS) Authorizing Legislation: Sec. 2691, PHS Act, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87.

including 14 HIV/AIDS community discussions held across the country, an online suggestions process, various expert meetings and other inputs. Senior officials at HRSA were involved in a Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS.

The NHAS has three primary goals:

1. reducing the number of people who become infected with HIV;
2. increasing access to care and optimizing health outcomes for people living with HIV; and
3. reducing HIV-related health disparities.

Reaching these goals requires broad support across federal, state, local, and tribal governments, business, faith-based communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others. The HIV/AIDS Bureau (HAB) and the Ryan White HIV/AIDS Program are playing an essential role in meeting these NHAS goals, both because of the program's critical role in filling gaps in the health system, but also the unique capacity, experience, and expertise of the Ryan White HIV/AIDS Program to meet the diverse and challenging health care and related needs of people living with HIV/AIDS.

The second goal of the NHAS, to increase access to care and improve health outcomes for people living with HIV, has two targets directly related to the mission of the HIV/AIDS Bureau:

1. to increase the proportion of newly diagnosed patients linked to care within three months of their HIV diagnosis from 65% to 85%; and
2. to increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%.

HAB is working closely with its grantees to meet these goals. Progress in achieving these goals to date shows that of the 291,449 HIV+ clients who had at least one Ryan White funded outpatient ambulatory medical care (OAMC) visit in CY 2010 and at least one OAMC visit date, 220,645 (76%) had at least two OAMC visit dates at least three months apart.

Affordable Care Act

In FY 2014, the Ryan White HIV/AIDS program will be directly affected by the Affordable Care Act (ACA) health insurance expansions as uninsured individuals living with HIV/AIDS begin to enroll in private health insurance or expanded Medicaid. By statute, Ryan White-funded programs are the "payer of last resort" – as such, they fill gaps in care not covered by other resources, including private and public health insurance.

Services provided by the RWP are critical for maintaining PLWH in treatment, which contributes to the nation's overall public health. Recent research shows that treatment reduces HIV transmission by 96%, highlighting the importance of ensuring that all individuals living with HIV have access to care and are prescribed antiretroviral medications (ARVs). By keeping PLWH in care and on medications, the Ryan White program plays a critical role in preventing the spread of HIV epidemic, as people living with HIV who are on antiretrovirals and virally suppressed are much less likely to transmit the infection.

Data from the Center for Disease Control and Prevention indicates that currently only approximately 25 percent of individuals living with HIV in the United States receive ARV treatment resulting in suppression of the virus. Such findings underscore the importance of supporting effective interventions for linking HIV positive individuals into care, retaining them in care, and helping them adhere to their ARV treatment regiments. The continuum of interventions that begin with outreach and testing and result in ARV treatment and viral suppression is generally referred to as the HIV Care Treatment Cascade.

Currently Ryan White grantees use at least 75 percent of their grants to provide life-saving medications and core medical services to more than half a million low-income people with HIV/AIDS, over a quarter of whom have no health insurance. The remaining 25 percent or less of funding is used by grantees optimize each step in the continuum of care by getting individuals living with HIV into regular care and started and maintained ARV treatment. Beginning in FY 2014, as the number of insured RW clients increase, RW grantees will more easily be able to use a greater percentage of their grants to support services not covered by public or private insurance but which are essential to getting people living with HIV into care and on medications that suppress the virus and help prevent the spread of the epidemic.

The FY 2014 request reflects our continued support of the Ryan White program while assessing the preliminary impact of and adapting to the changes that the Affordable Care Act and the health insurance expansions have on the Program's provision of services and impact on improving health outcomes for PLWH.

The actual scope of coverage for Ryan White HIV/AIDS services in the context of expanded Medicaid program will be determined by states. It is likely that in many states, coverage for the Ryan White service categories will be included in the essential health benefits package and reflected in each state's individualized Medicaid, Basic Health Plans, and qualified health plans offered through the Marketplaces (aka Exchanges). Examples of services likely captured within the 10 mandatory essential health benefits categories for which the Ryan White program will no longer have to pay full costs include ambulatory health services, prescription drugs, mental health services, substance abuse services, rehabilitation services, and some early intervention services. It is anticipated, however, that on average coverage will not be adequate for the care and treatment of people living with HIV/AIDS (PLWH) due to plan limitations on the scope of coverage. This projection is strongly supported by the fact that approximately 70 percent of current Ryan White clients already have private insurance, Medicaid and/or Medicare. Other Ryan White services that may not be covered include oral health care, medical case management, treatment adherence counseling, psychosocial support services, outreach and a host of other support services that in many cases are critical to identifying, linking and maintaining people living with HIV and AIDS in care.

We continue to collaborate with HHS agencies and other Federal Departments on how Affordable Care Act policies and regulations may affect the Ryan White HIV/AIDS Program.

The Ryan White HIV/AIDS Program demonstrates a comprehensive and data-driven approach in how government has targeted dollars toward the development of a highly effective service delivery system. The distinct components of the Ryan White HIV/AIDS Program serve very specific purposes. The FY 2014 President's Budget Request of $2.41 billion for the Ryan White HIV/AIDS Program includes:

Part A – $666.1 million, which provides grants for 24 Eligible Metropolitan Areas (EMAs) and 28 Transitional Grant Areas (TGAs) disproportionately affected by HIV/AIDS;

Part B – $1,370.8 million, which provides grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services; this includes $943.3 million to provide access to FDA approved, HIV-related medications through the AIDS Drug Assistance Program (ADAP). The ADAP serves primarily low-income PLWHA who have limited or no access to needed medication, and is the nation's prescription drug safety net for PLWHA;

Part C – $225.1 million, which provides grants directly to 357 grantees (i.e. Federally-qualified health centers, family planning clinics, rural health clinics, Indian Health Service facilities; community-based organizations, and nonprofit faith-based organizations) to support outpatient HIV early intervention services and ambulatory care;

Part D – $77.2 million, which provides grants to 114 community based and non-profit private and public organizations to support family-centered, comprehensive care to HIV-infected women, infants, children and youth and support to their affected family members;

Part F –

- $34.5 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through 11 Regional Centers, 130 Local Performance Sites and 5 National Centers;
- $13.5 million for the HIV/AIDS Dental Reimbursement Program, a program that provides reimbursement to dental schools, hospitals with postdoctoral dental education programs, and colleges with dental hygiene programs for uncompensated costs incurred in providing oral health treatment to patients with HIV disease; and for 12 Community-Based Dental Partnership Grants to provide support to dental clinicians to provide increased access to oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those located in community-based settings; and
- $25 million for Special Projects of National Significance (SPNS) funded from the Department PHS Act evaluation set-aside. Examples of SPNS initiatives include expanding the capacity of grantees to: 1) utilize standard electronic client information data systems to report client level data; 2) take a more systems level/public health approach to test people who do not know their status and link them to care; 3) develop innovative models to reach women of color and link them to and retain them in care; and 4) expand access to Hepatitis C Virus (HCV) treatment through the development of models to integrate HCV care into HIV primary care. These SPNS initiatives reflect priorities of the NHAS, Patient Protection and Affordable Care Act, and the Departmental Hepatitis Plan.

Ryan White Minority AIDS Initiative (MAI): Within the total amount included for the Ryan White HIV/AIDS Program, the FY 2014 President's Budget requests $161.0 million to address the disproportionate impact of HIV/AIDS on communities of color. Ryan White MAI dollars focus specifically on the elimination of racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care and treatment in the United States. To achieve this objective, the Ryan White HIV/AIDS Program uses MAI funds to conduct the following activities:

- Provide service grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities;

- Increase the training of health care professionals in order to expand the number of them with HIV treatment expertise who are then better able to provide medical care for racial and ethnic minority adults, adolescents, and children with HIV disease; and

- Support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the AIDS Drug Assistance Program (ADAP).

Minority AIDS Initiative (MAI) Funding

(Whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Part A	$51,431,000	$54,105,000	$51,528,000
Part B	9,644,000	10,145,000	9,662,000
Part C	67,503,000	71,012,000	67,631,000
Part D	22,500,000	23,671,000	22,543,000
Part F – AETC	9,644,000	10,144,000	9,662,000
Part F – Dental	---	---	---
Total MAI Funding	$160,722,000	$169,077,000	$161,026,000

Program Accomplishments

The Ryan White HIV/AIDS Program has developed new outcome measures and other indicators that allow for ongoing monitoring of the Minority AIDS Initiative MAI program's effectiveness. These indicators include:

1. client-level health outcomes (the MAI client-level health outcomes indicators facilitate improving and stabilizing client CD4 counts and reducing client viral load counts);
2. rates of kept appointments and retention in care; and
3. the proportion of health care providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Program Performance: The HIV/AIDS Bureau continues to demonstrate excellent performance in improving access to health care, improving health outcomes, improving quality of health care, and promoting efficiency. The Ryan White HIV/AIDS Program uses various strategies to achieve its performance goals including:

1. Targeting resources to high-risk areas;
2. Ensuring availability, access to and excellence of critical HIV-related care and support services and optimizing health outcomes for people living with HIV;
3. Working to assure patient adherence;
4. Directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection;
5. Tailoring services to populations known to have delayed care-seeking behaviors (e.g., by varying hours; offering care in various sites, offering linguistically and culturally appropriate services); and
6. Collaborating with other programs and providers for referrals to Ryan White HIV/AIDS Program service providers.

Improving Access to Health Care: The Ryan White HIV/AIDS Program works to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately affected by HIV/AIDS including racial/ethnic minorities. The Ryan White HIV/AIDS Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities than their representation among AIDS cases as reported by the Centers for Disease Control and Prevention (CDC). The proportion of Ryan White clients who were racial/ethnic minorities in 2007 was 72%, compared to the 64.1% of CDC-reported AIDS cases. In 2008, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities compared to 65.9% of CDC-reported AIDS cases. In FY 2009, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 66.4% of CDC-reported AIDS cases. In FY 2010, the proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs was 72%, compared to 66.5% of CDC-reported AIDS cases among racial/ethnic minorities. In 2011, 72.2% of Ryan White HIV/AIDS Program clients were racial/ethnic minorities; at this time CDC data are not available for comparison.

In 2007 and 2008, 33% of persons served by the Ryan White HIV/AIDS Program were women. This compares to 23% of CDC reported AIDS cases among women in 2007 and 2008. In FY 2009, 32% of the Ryan White HIV/AIDS Program clients were women, compared to the 23.3% of CDC-reported AIDS cases. In FY 2010, the proportion of women in Ryan White HIV/AIDS funded programs was 31%, compared to 23.5% of CDC-reported AIDS cases among women. In 2011, 30.1% of Ryan White HIV/AIDS Program clients were women; at this time CDC data are not available for comparison.

Improving Health Outcomes: In FY 2011, the AIDS Drug Assistance Program (ADAP) served 211,037 clients through State ADAPs, exceeding the target of 153,335. The number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs in FY 2010 was 208,809. In FY 2009, the AIDS Drug Assistance Program (ADAP) served 194,039 clients through State ADAPs. In FY 2008, the AIDS Drug Assistance Program (ADAP) served 175,194 clients through State ADAPs. The number of ADAP clients served through State ADAPs annually in 2010 was 14,770 persons above the 2009 annual results. In 2007, the ADAP served 163,925 clients through State ADAPs. FY 2007 results cannot be compared with the FY 2007 target because the actual performance is based on the revised measure using annual data and the target is based on the previous measure utilizing quarterly Program data. FY 2007 – FY 2010 represent a substantial growth in the persons served in the State ADAP programs of 21.5% or 44,884

additional ADAP clients served in these four years. About 46% of HIV positive people in care in the U.S. received their medications through State ADAPs in 2010.

CDC estimates that 1.039 to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 18 percent are unaware of their serostatus. Approximately 50,000 new infections occur each year. In FY 2010, 1,205,257 persons learned their serostatus from the Ryan White HIV/AIDS Program, exceeding the target by 327,732 persons. In FY 2009, 871,696 persons learned their serostatus from the Ryan White HIV/AIDS Program. The number of persons learning their serostatus from the Ryan White HIV/AIDS Program was 739,779 in FY 2008. In 2007, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 738,181. These four years represent a growth of 467,076 persons who learned their serostatus. These efforts demonstrate that the Ryan White HIV/AIDS Program has made important strides in testing people in the United States who do not know their serostatus.

Mother-to-child transmission in the U.S. has decreased dramatically since its peak in 1992 due to the use of anti-retroviral therapy which significantly reduces the risk of HIV transmission from the mother to her baby. In FY 2011, the Ryan White HIV/AIDS Program provided 92.3% of HIV-positive pregnant women with anti-retroviral medications, exceeding the target. The proportion of Ryan White Program HIV-positive pregnant women receiving anti-retroviral medications in 2008, 2009, and 2010 was 87%. In FY 2007, the Ryan White HIV/AIDS Program provided 85.1% of HIV-positive pregnant women in the Program with anti-retroviral medications. The percentage of HIV-positive pregnant women in the Ryan White HIV/AIDS Program receiving anti-retroviral medication has grown 7.2 percentage points in the years FY 2007 – FY 2011.

Improving the Quality of Health Care: A major focus of the Ryan White HIV/AIDS Program is improving the quality of care that its clients receive. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directed grantees to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies; and that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. This legislative requirement continues in the Ryan White HIV/AIDS Extension Act of 2009. The proportion of new Ryan White HIV/AIDS Program-funded primary care medical providers that implemented a quality management program by 2008 was 92.3%. In 2009, 94.5% of Ryan White HIV/AIDS Program-funded primary medical care providers had implemented a quality management program. In 2010, 95.2% had implemented such a program. Improvements continued in 2011 with 95.7% of medical care providers implementing a quality management program, meeting the target.

CD4 cell measurement is a key test used to assess the functioning of the immune system, guide decisions about when to start HIV treatment, and monitor effectiveness of HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide when to start HIV treatment and to monitor response to therapy. The proportion of new Ryan White HIV/AIDS Program clients who were tested for CD4 and viral load in 2008 and 2009 were: CD4-86.4% and Viral Load-84.4% and CD4-84.7% and Viral Load-81.3%, respectively. In 2010, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.7% of new clients and viral load testing to 82.9% of these new clients. The implementation of HRSA/HAB's new client-level data reporting system, the Ryan White Services Report (RSR),

included a change in how CD4 count and viral load data are reported. These data are now collected for all HIV infected clients that are served, rather than just new clients. The FY 2011 result was 87.4% were tested for CD4 and 83.6% were tested for viral load. The 2011 results fell short of the target for CD4 tests by 0.8 percentage points and fell short of the target for viral load tests by 1.4 percentage points.

Promoting Efficiency: State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, and enables ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; direct negotiation of pharmaceutical pricing; reducing ADAP formularies; capping enrollment; and lowering financial eligibility levels. ADAP savings strategies on medications resulted in a savings of $265.2 million in 2007 and a $374.2 million savings in 2008. In 2009, the ADAP program had cost-savings on medications of $487.3 million. In 2010, ADAP cost-savings strategies for medication resulted in savings of $551.2 million, exceeding the target by $171 million.

Funding History

FY	Amount[159]
FY 2005	$2,073,296,000
FY 2006	$2,061,275,000
FY 2007	$2,137,795,000
FY 2008	$2,166,792,000
FY 2009	$2,238,421,000
FY 2010	$2,312,179,000
FY 2011	$2,336,665,000
FY 2012	$2,392,178,000
FY 2013	$2,361,479,000
FY 2014	$2,412,178,000

Budget Request

The FY 2014 President's Budget Request for the HIV/AIDS Programs of $2,412,178,000 is $20,000,000 above the FY 2012 Enacted Level.

In FY 2014, the Program will continue its central goals of 1) ensuring that individuals living with HIV have access to care and 2) improving the quality of life of those infected with HIV and those affected by the epidemic. In cities and states where the number of insured RW clients begins to increase, the program will continue to provide services not covered by insurance but which are critical to providing quality comprehensive HIV care. RW grantees will also focus on working with various partners in their communities to improve outcomes across the HIV Treatment Cascade, so that individuals diagnosed with HIV get linked into care and started on ARV treatment as early as possible.

The Program will continue to support the NHAS and its three primary goals:

[159] Includes SPNS.

1. Reducing the number of people who become infected with HIV;
2. Increasing access to care and optimizing health outcomes for people living with HIV; and
3. Reducing HIV-related health disparities.

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV. The Minority AIDS Initiative (MAI) budget will continue the Ryan White HIV/AIDS Program's efforts to reduce HIV/AIDS-related health disparities in communities of color, strengthen organizational capacity, and expand HIV-related services to minority populations. The MAI funds will support primary health care and related services; outreach and education to improve minority access to HIV/AIDS treatment medications; and targeted, multidisciplinary education and training programs for health care providers treating minority PLWHA.

The Program will continue to appropriately target men who have sex with men, racial/ethnic minorities, specifically Black and Latino populations, because these groups are disproportionately impacted by HIV/AIDS. In addition, the NHAS targets these populations for more resources given their increased risk for HIV. Men who have sex with men are over forty times more likely to become infected with HIV compared with other men, and young black men are the only population in the U.S. in which new HIV infections are increasing. At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women. Black and Hispanic women represent 28% of all U.S. women. However, women in these 2 groups accounted for 78.9% of the estimated persons living with an AIDS diagnosis according to CDC's HIV Surveillance Report in 2010. With regard to women, data from the 2010 CDC Surveillance Report in August 2011 show that together, black and Hispanic women represent 28% of all U.S. women. However, women in these two groups accounted for 64% of the estimated total of AIDS diagnoses for women. The FY 2014 targets for the proportion of racial/ethnic minorities and women served in Ryan White HIV/AIDS-funded programs are 5 percentage points above CDC reported national AIDS prevalence data.

In FY 2014, the Program will aim to reach the following performance targets. The number of clients served by ADAPs given the FY 2014 Budget Request is predicted to be 218,942 clients. The ADAP target reflects adjustments for our current performance and resources, in addition to medical inflation, rising health insurance premiums, reported decreases in state contributions and decreases in drug rebates, and increased costs of laboratory testing associated with antiretroviral use (e.g. resistance, tropism and Human Leukocyte Antigen (HLA) testing for patients). The FY 2014 target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 879,546. The budget will also support the Program's ongoing efforts to improve the quality of health care for PLWHA. The FY 2014 target for the percentage of Ryan White HIV/AIDS Program-funded primary care providers that will have implemented a quality management program is 95.7%. The FY 2014 targets for new HIV infected clients who are tested for CD4 and for viral load are 88.2% and 84.3%, respectively.

In FY 2014, the Ryan White HIV/AIDS Program will continue to coordinate and collaborate with other Federal, State, and local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. The Program's work in collaboration with others has been a key to its success. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), Indian Health Service (IHS), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ) as well as other HRSA-funded programs.

For FY 2014, the Ryan White HIV/AIDS Program proposes two new evaluations:

1. **An Examination of How Ryan White HIV/AIDS Program Services "Care Completion" Services Covered by Other Payer Sources: Medicaid, Medicare, and Private Insurance (including Health Exchanges**): Although the Affordable Care Act (ACA) will expand coverage for certain services provided to uninsured and underinsured HIV-positive clients currently served by the Ryan White HIV/AIDS Program, Ryan White funding will still be needed to complete care coverage, e.g. provide services critical to good outcomes across the HIV Treatment Cascade not covered or inadequately covered by Medicaid expansion, Benchmark Health Plans (BHPs), or private plans in a Health Care Marketplace (aka Exchange). This proposed study will examine the degree to which Ryan White-funded services are needed to complete the care coverage provided through private and public health insurance.

2. **Assessing the Impact of Full Implementation of the Affordable Care Act on the Ryan White HIV/AIDS Program**: Full implementation of the Affordable Care Act will provide many benefits to people living with HIV/AIDS (PLWHA) who historically have experienced difficulty in obtaining health insurance coverage. Under the Affordable Care Act people living with HIV covered by Medicaid expansion, or health exchanges will gain access to health care services that they previously received through the Ryan White Program. This proposed study will examine changes in the demand for Ryan White-funded services and changes in service use by type of service in Ryan White HIV/AIDS Programs with the implementation of the Affordable Care Act.

The Ryan White HIV/AIDS Program funds two IT Investments. It funds the HRSA-HAB Upgrading & Maintaining RW CAREWare investment, which directly supports the strategic and performance outcomes of the HIV/AIDS Bureau (HAB) by providing to grantees and providers a free and technically-supported software to manage their HIV care, treatment, and services data at the clinic level and be able to report these data in the required format to HAB at the end of the year. The software also generates HAB's performance measures in a standardized fashion, outcomes that are essential for monitoring and ultimately improving the quality of HIV care.

The Ryan White HIV/AIDS Program's investment in the HRSA-OIT Electronic Handbooks (EHBs) supports the strategic and performance outcomes of the program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner. HRSA's EHBs support the Ryan White HIV/AIDS Program with program

administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
16.1: Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[160] *(Outcome)*	FY 2005: 412,000/ 195,000 (Baseline)	N/A	422,300/ 199,875	N/A
16.I.A.1: Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. *(Outcome)*	FY 2011: 72.2% (CDC = Not Yet Available for Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.I.A.2: Proportion of women in Ryan White HIV/AIDS funded-programs served. *(Outcome)*	FY 2011: 30.1% (CDC = Not Yet Available for Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.III.A.2: Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load. *(Output)*[161]	FY 2011: CD4 – 87.4%Viral Load – 83.6% Target: CD4-88.2%, Viral Load-84.3% (Target Not Met but Improved)	CD4 = 88.2% Viral Load = 84.3%	CD4 = 88.2% Viral Load = 84.3%	Maintain
16.2: Reduce deaths of persons due to HIV infection.[162] *(Outcome)*	FY 2003: 4.7 per 100,000 (Baseline)	N/A	3.1 per 100,000	N/A
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	FY 2011: 211,037 Target: 208,836 (Target Exceeded)	217,324	218,942	1,618

[160] These are long-term measures without annual targets. FY 2014 is the long-term target year.
[161] The implementation of HRSA/HAB's new client-level data reporting system, the Ryan White Services Report (RSR), included a change in how CD4 count and viral load data are reported. These data are now collected for all HIV-positive clients who receive outpatient ambulatory medical care, rather than just new clients. The FY 2011 result is from the new data system.
[162] These are long-term measures without annual targets. FY 2014 is the long-term target year.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2010: 1.2 M Target: 572,397 (Target Exceeded)	872,565	879,546[163]	6,981
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. *(Output)*	FY 2011: 92.3% Target: 90% (Target Exceeded)	90%	90%	Maintain
16.3: Percentage of Ryan White HIV/AIDS Program-funded HIV primary medical care providers that have implemented a quality management program and will meet two "core" standards included in the October 10, 2006 "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents".[164]	FY 2005: 63.7% (Baseline)	N/A	90%	N/A
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. *(Output)*	FY 2011: 95.7% Target: 95.7% (Target Met)	95.7%	95.7%	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Efficiency)*	FY 2010: $551.2M Target: $487.3M (Target Exceeded)	Sustain FY 11 results	Sustain FY 13 results	N/A

[163] The Ryan White Services Report (RSR) included a change in how HIV testing is reported. Previously, Ryan White-funded providers reported on all HIV testing, regardless of the source of funding for testing. Approximately 40% of HIV testing reported was not supported with Ryan White funds. Under the new reporting requirements, only HIV testing funded by the Ryan White HIV/AIDS Program is reported. The FY2014 target reflects this change.

[164] These are long-term measures without annual targets. FY 2014 is the long-term target year.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
20.II.A.1 Number of female clients[165] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. *(Output)*	FY 2010: 53,753 Target: 51,316 (Target Exceeded)	49,802	52,790	+2,988

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	114	114	114
Average Award	$599,393	$602,000	$599,393
Range of Awards	$100,000-$2,260,049	$100,000-$2,270,000	$100,000-$2,260,049

[165] Female clients counted are age 13 and above.

Emergency Relief Grants – Part A

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$666,071,000	$675,366,000	$666,071,000	---
MAI (non add)	51,431,000	54,105,000	51,528,000	+$97,000
SPNS	7,588,000	7,588,000	7,588,000	---
Total Funding	$673,659,000	$682,954,000	$673,659,000	---
FTE	36	36	36	---

Authorizing Legislation: Secs. 2601-10, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2014 Authorization…….……..…….Expired

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part A funds are used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. Part A grants are distributed to metropolitan areas experiencing the greatest burdens of the country's HIV/AIDS epidemic, and provide those communities with resources they need to confront the highly concentrated epidemic within the jurisdiction. Part A grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan will also play a vital role in implementation of the National HIV/AIDS Strategy through the mobilization of the Ryan White resources in the "Twelve Cities Initiative." This initiative is a key part of the Department of Health and Human Services (HHS) strategy to better coordinate HIV prevention, care, and treatment across HHS, state, and local partners.

Part A of the Ryan White HIV/AIDS Program prioritizes primary medical care, access to anti-retroviral therapies, and other core services as the areas of greatest need for persons with HIV disease. The grants fund systems of care to provide 13 core medical services and additional support services for individuals with HIV/AIDS in 24 Eligible Metropolitan Areas (EMAs), which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 transitional grant areas (TGAs) (jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years). Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula based on the number of living cases of HIV/AIDS in the EMAs and TGAs. The statute also includes a hold harmless provision which limits a potential loss in EMA's formula award to a specific percentage of the amount of the formula award in the previous year. The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the EMAs and TGAs, as Minority AIDS Initiative (MAI) grants and as grants to the 4 specific states. MAI grant awards are determined based on the number of minorities living with HIV and AIDS in a jurisdiction.

In 2010, 75% of Part A clients were people of color and 30% were women. In 2007, Part A provided 2.65 million visits for health-related care (primary medical, dental, mental health,

substance abuse, rehabilitative, and home health) and 2.60 million visits were provided in 2008. In FY 2009, Part A provided 2.59 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). In FY 2010, Part A provided 2.63 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). This met the FY 2010 target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance, and program monitoring including performance reviews, and Information Technology costs.

Use of funds:

Part A supports a comprehensive continuum of quality, community-based care for low-income individuals and families with HIV/AIDS. Eligible service categories include core medical services and support services, as defined by the legislation. Use of Part A Ryan White funds is locally determined, guided by a Planning Council, mandated by statute and established by the chief elected official (CEO) of each EMA or TGA. Eligible organizations for sub-grants under Part A include ambulatory care facilities, community health centers, and a variety of other organizations serving PLWH.

Funding History

FY	Amount[166]
FY 2005	$610,094,000
FY 2006	$603,576,000
FY 2007	$603,993,000
FY 2008	$627,149,000
FY 2009	$663,082,000
FY 2010	$678,074,000
FY 2011	$672,529,000
FY 2012	$666,071,000
FY 2013	$675,366,000
FY 2014	$666,071,000

Budget Request

The FY 2014 President's Budget Request for the Ryan White HIV/AIDS Part A Program of $666,071,000 is equal to the FY 2012 Enacted Level and will support program activities and services for PLWHA in the 24 Eligible Metropolitan Areas (EMAs) and 28 Transition Grant Areas (TGAs).

In FY 2014, many Part A grantees will be directly affected by the Affordable Care Act health insurance expansions as uninsured individuals living with HIV/AIDS begin to enroll in private health insurance or expanded Medicaid. In cities where the number of insured Ryan White clients begin to increase, Part A grantees will continue to provide services not covered by private

[166] Excludes comparable amounts for SPNS.

or public insurance but which are essential to 1) providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking individuals living with HIV into care and started on ARV treatment as early as possible. Supporting interventions that get people linked into care and on medications is critical to preventing the spread of the epidemic as studies have found that treatment reduces HIV transmission by 96 percent.

The FY 2014 target for the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) is 2.63 million visits. Part A funding will also contribute to achieving the FY 2014 targets for the Ryan White HIV/AIDS Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
17.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative[167], and home health). *(Output)*	FY 2010: 2.63 M Target: 2.63 M (Target Met)	2.63 M	2.63 M	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards[168]	52	52	52
Average Award	$12,259,673	$12,307,692	$12,259,673
Range of Awards	$1,892,647 - $120,489,151	$1,892,647 - $120,489,151	$1,892,647 - $120,489,151

[167] Rehabilitative services are a support service and visit data is not collected for support services.
[168] Awards to 24 EMAs and 28 TGAs in FY 2012 = 52.

Part A – FY 2012 Formula, Supplemental & MAI Grants[169]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[170]	Supplemental	MAI	Total
Atlanta, GA	$13,637,549	$5,382,762	$1,963,609	$20,983,920
Baltimore, MD	13,876,932	5,099,003	2,044,355	21,020,290
Boston, MA	9,212,901	3,824,902	906,427	13,944,230
Chicago, IL	17,548,172	5,519,319	2,153,842	25,221,333
Dallas, TX	9,944,346	4,018,604	1,096,324	15,059,274
Detroit, MI	5,781,850	2,302,078	801,302	8,885,230
Ft. Lauderdale, FL	10,117,916	4,053,622	1,219,120	15,390,658
Houston, TX	13,003,056	5,212,773	1,773,377	19,989,206
Los Angeles, CA	26,338,159	11,226,557	3,286,848	40,851,564
Miami, FL	16,183,910	6,149,956	2,552,759	24,886,625
Nassau-Suffolk, NY	4,455,844	1,416,090	425,646	6,297,580
New Haven, CT	5,117,731	1,415,225	461,769	6,994,725
New Orleans, LA	4,925,025	1,734,063	607,715	7,266,803
New York, NY	84,574,079	26,208,750	9,706,322	120,489,151
Newark, NJ	9,477,245	3,343,028	1,313,733	14,134,006
Orlando, FL	5,950,279	2,124,843	720,892	8,796,014
Philadelphia, PA	15,640,053	6,279,723	2,116,936	24,036,712
Phoenix, AZ	5,659,065	1,914,240	434,146	8,007,451
San Diego, CA	7,744,504	3,249,289	671,685	11,665,478
San Francisco, CA	15,406,181	4,640,758	797,500	20,844,439
San Juan, PR	11,218,774	2,734,186	1,287,563	15,240,523
Tampa-St. Petersburg, FL	6,454,492	2,468,833	607,938	9,531,263
Washington, DC-MD-VA-WV	20,404,993	7,696,185	3,094,491	31,195,669
West Palm Beach, FL	6,499,851	1,876,972	677,724	9,054,547
Subtotal EMAs	**$339,172,907**	**$119,891,761**	**$40,722,023**	**$499,786,691**

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$2,918,525	$1,116,783	$263,820	$4,299,128
Baton Rouge, LA	2,782,277	1,067,078	408,424	4,257,779
Bergen-Passaic, NJ	2,730,706	1,057,101	335,954	4,123,761

[169] Awards to EMAs and TGAs include prior year unobligated balances.
[170] EMAs' Hold Harmless Amounts are included in their Formula Awards. TGAs are not eligible for Hold Harmless.

TGAs	Formula	Supplemental	MAI	Total
Charlotte-Gastonia, NC-SC	3,852,530	1,211,909	506,392	5,570,831
Cleveland, OH	2,928,076	1,131,137	327,231	4,386,444
Denver, CO	5,476,055	1,727,197	337,408	7,540,660
Ft. Worth, TX	2,679,135	909,083	263,485	3,851,703
Hartford, CT	2,381,807	971,041	281,043	3,633,891
Indianapolis, IN	2,685,502	1,004,150	228,368	3,918,020
Jacksonville, FL	3,802,869	1,299,149	472,170	5,574,188
Jersey City, NJ	3,254,054	1,352,757	441,639	5,048,450
Kansas City, MO	2,943,992	1,136,818	242,571	4,323,381
Las Vegas, NV	3,853,167	1,417,953	338,974	5,610,094
Memphis, TN	4,569,428	1,586,977	680,520	6,836,925
Middlesex-Somerset-Hunterdon, NJ	1,823,442	660,519	213,270	2,697,231
Minneapolis-St. Paul, MN	3,782,495	1,445,581	313,699	5,541,775
Nashville, TN	3,153,459	1,094,455	292,674	4,540,588
Norfolk, VA	3,846,800	1,288,030	512,431	5,647,261
Oakland, CA	4,609,367	1,856,223	549,448	7,015,038
Orange County, CA	4,115,892	1,557,247	370,511	6,043,650
Ponce, PR	1,230,696	445,773	216,178	1,892,647
Portland, OR	2,715,426	1,026,555	107,027	3,849,008
Riverside-San Bernardino, CA	5,431,312	2,040,388	440,520	7,912,220
Sacramento, CA	1,866,724	778,195	149,301	2,794,220
St. Louis, MO	4,185,512	1,600,602	429,001	6,215,115
San Antonio, TX	3,058,594	1,160,541	380,577	4,599,712
San Jose, CA	2,013,225	805,506	211,481	3,030,212
Seattle, WA	4,828,555	1,858,594	275,227	6,962,376
Subtotal TGAs	**$93,519,622**	**$34,607,342**	**$9,589,344**	**$137,716,308**
Total EMAs/TGAs	**$432,692,529**	**$154,499,103**	**$50,311,367**	**$637,502,999**

HIV Care Grants to States – Part B

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,360,827,000	$1,328,722,000	$1,370,827,000	+$10,000,000
ADAP (non add)	933,299,000	903,797,000	943,299,000	+10,000,000
MAI (non add)	9,644,000	10,145,000	9,662,000	+18,000
SPNS	14,077,000	14,077,000	14,077,000	---
Total Funding	$1,374,904,000	$1,342,799,000	$1,384,904,000	+$10,000,000
FTE	56	56	56	---

Authorizing Legislation: Secs. 2611-31, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2014 Authorization……Expired

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part B, the largest of the Ryan White HIV/AIDS programs, provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and 5 U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV/AIDS, including outpatient medical care, oral health care, home- and community-based services, continuation of health insurance coverage, prescription drugs, HIV care consortia, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services. Seventy-five percent of Part B funds must be used to support 13 core medical services. Part B funds are distributed through base and supplemental grants, ADAP and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants**.** Through FY 2013, the statute includes a hold harmless provision which limits a potential loss in State's award to a specific percentage of the amount of the award in the previous year. The FY 2013 Hold Harmless amount is 92.5%. The FY 2012 Hold Harmless amount was 100%. In FY 2011, the Hold Harmless amount was 100%. In FY 2010, the Hold Harmless amount was 95%. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. Supplemental grants are available to states with demonstrated need and less than 5% unobligated prior year funds. Emerging communities are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years and apply for supplemental funding through a grant application.

Over the past four years, the convergence of several factors has resulted in significant budget challenges for the Part B program. These include the economic downturn, a national HIV testing initiative that has brought more people infected with HIV into care, federal recommendations for earlier treatment of HIV, and continued improvements in HIV care and treatment that has prolonged survival, increasing HIV prevalence. Part B grants provide critical resources for

States and territories to meet these increased demands and provide life-saving HIV/AIDS care, treatment, and support for people living with HIV/AIDS without access to health care.

Congress designates a portion of the Part B award to support the ADAPs. The ADAPs provide FDA-approved, prescription medications for people with HIV/AIDS who have limited or no prescription drug coverage. The majority of ADAP funds are distributed by a formula based on living HIV/AIDS cases, although 5% of the funds are set aside for states with severe need. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

Due to the combination of factors mentioned above, a number of States implemented or significantly increased waiting lists for people to enroll in their ADAP programs and implemented other cost-containment mechanisms such as restricting the income eligibility for their programs. In FY 2010, FY 2011, and FY 2012, HHS took several actions to address the ADAP crisis:

- In FY 2010, HHS used emergency authority to redistribute and transfer $25 million from other HHS resources to provide direct assistance to help State ADAP programs eliminate their waiting lists and to address cost containment measures.

- The FY 2011 Budget included an additional $50 million for State ADAPs.

- In FY 2012, $75 million in emergency funding for ADAPs included $35 million in new funding announced by President Obama on World AIDS Day and $40 million in continuation emergency funding first appropriated in FY 2011.

As a result of the increased investments in ADAP in FY 2012, as of March 14, 2013, state waiting lists have decreased to 65.

The Part B programs have been successful in helping to ensure that people living with HIV/AIDS can get the care and services they need to stay healthy longer. The number of visits for health-related services demonstrates the effectiveness of the Part B program in delivering primary care and related services for individuals infected with HIV by increasing the availability and accessibility of care. Part B programs provided 2.06 million visits in 2007. In FY 2008, Part B provided 2.02 million visits for health-related care. In FY 2009, the Part B program provided 2.11 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). In FY 2010, the Part B program provided 2.20 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health), which met the FY 2010 target. Additionally, the 2.20 million visits in FY 2010 was an increase of 90,000 visits over the number of visits in FY 2009. ADAP served 163,925 clients in 2007 and 175,194 clients in 2008. In FY 2009, 194,039 clients were served through State ADAPs. In FY 2010, 63.4% of the 208,809 clients served by ADAPs were people of color. Nationally, more than 82.8% of ADAP clients had incomes at or below 200% of the federal poverty level. In FY 2011, 211,037 ADAP clients were served through State ADAPs, exceeding the target. Slightly more than 63.3% of those served in 2011 were people of color.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount[171]	ADAP (Non-Add)
FY 2005	$1,121,836,000	($787,521,000)
FY 2006	$1,119,744,000	($789,005,000)
FY 2007	$1,195,500,000	($789,546,000)
FY 2008	$1,195,248,000	($794,376,000)[172]
FY 2009	$1,223,791,000	($815,000,000)
FY 2010	$1,276,791,000	($858,000,000)
FY 2011	$1,308,141,000	($885,000,000)
FY 2012	$1,360,827,000	($933,299,000)
FY 2013	$1,328,722,000	($903,797,000)
FY 2014	$1,370,827,000	($943,299,000)

Budget Request

The FY 2014 President's Budget Request for the Ryan White HIV/AIDS Part B Program of $1,370,827,000 is $10,000,000 above the FY 2012 Enacted Level. This request will support the provision life-saving medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions.

In FY 2014, many Part B grantees will be directly affected by the Affordable Care Act health insurance expansions as uninsured individuals living with HIV/AIDS begin to enroll in private health insurance or expanded Medicaid. In states where the number of insured Ryan White clients begin to increase, Part B grantees will continue to provide services not covered by private or public insurance but which are essential to 1) providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking individuals living with HIV into care and started on ARV treatment as early as possible. Supporting interventions that get people linked into care and on medications is critical to preventing the spread of the epidemic as studies have found that treatment reduces HIV transmission by 96 percent.

States continue to face fiscal challenges and shortfalls in meeting the growing HIV epidemic in their jurisdictions. In addition, as a result of the clinical trial – HPTN O52 – which showed that antiretrovirals used by HIV-infected individuals substantially reduced transmission to their partners, the demand for ADAP will increase. The FY 2014 President's Budget Request reflects a strong commitment to partnering with States to respond to the HIV epidemic.

[171] Excludes comparable amounts for SPNS.
[172] FY 2008 actual expenditure was $813,858,028 due to the hold harmless provision. For FY 2008, the statute requires that the grant not be less than 100% of the FY 2007 total grant.

As of March 14, 2013, the AIDS Drug Assistance Program (ADAP) waiting list includes ~~51~~ 65 people in 2 states, with many other states curtailing their programs to avoid waiting lists. The budget maintains and bolsters the Federal commitment to supporting States and their ADAP programs. The FY 2014 President's Budget Request includes $943,299,000 for AIDS drug assistance programs to provide access to life saving HIV related medications. The FY 2014 target is 218,942. This represents an increase of 1,618 clients served given a budget increase of $10,000,000 over the FY 2012 Enacted Level in the ADAP earmark. This ~~-~~federal investment, combined with the Affordable Care Act health insurance expansions, will help ensure that all people living with HIV/AIDS have access to life-saving medications that suppress the virus and prevent the spread of the epidemic.

HRSA has developed a model for estimating the marginal cost of serving ADAP clients. The model takes into account many of the factors affecting purchasing power, such as increases in cost of HIV/AIDS drugs; the legislative requirement that all State ADAPs maintain a minimum drug formulary, including new drug classes; and the impact of Medicare Part D, rebates, medical inflation and insurance coverage. The marginal cost model provided cost estimates based on the application of the model to informs the Program's projected target for number of ADAP clients from 2008 - 2012. During the FY 2013 and FY 2014 budget processes, the cost and program indexes and assumptions made in the marginal cost model were reviewed and the model retains utility in predicting ADAP performance targets, thus the models projection of the total ADAP earmark cost to support serving ADAP clients was extended through 2014 by using a linear trend model to estimate the per client costs. The FY 2014 target for the number of visits for health related care (primary, medical, dental, mental health, substance abuse, rehabilitative and home health) is 2.19 million visits.

Part B funding will also contribute to achieving the FY 2014 targets for the Ryan White Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
18.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative,[173] and home health). *(Output)*	FY 2010: 2.20 M Target: 2.19 M (Target Met)	2.19 M	2.19 M	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	59	59	59
Average Award	$20,856,875	$20,381,244	$21,027,092
Range of Awards	$17,006-$164,499,214	$50,000-$164,499,214	$50,000-$164,499,214

[173] Rehabilitative services are a support service and visit data is not collected for support services.

Part B – FY 2012 State Table[174]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$8,050,988	-	$14,459,478	$297,914	$135,882	$22,944,262
Alaska	500,000	$10,910	809,434	-	-	1,320,344
American Samoa	36,982	-	2,663	-	-	39,645
Arizona	4,038,207	-	12,283,684	-	-	16,321,891
Arkansas	3,574,096	-	4,869,589	-	43,819	8,487,504
California	35,088,003	2,129,954	124,924,051	171,147	1,136,154	163,449,309
Colorado	3,655,590	-	11,721,327	-	67,716	15,444,633
Connecticut	3,500,189	193,576	10,972,770	-	122,641	14,789,176
Delaware	2,407,139	-	3,146,550	198,014	39,151	5,790,854
District of Columbia	4,540,467	-	15,234,732	-	250,038	20,025,237
F. States Micronesia	50,000	-	8,186	-	-	58,186
Florida	31,750,741	1,862,436	107,486,273	469,741	1,200,417	142,769,608
Georgia	12,242,501	653,057	43,107,383	171,997	474,877	56,649,815
Guam	200,000	-	86,530	-	-	286,530
Hawaii	1,434,640	-	2,208,862	-	17,354	3,660,856
Idaho	574,817	-	1,350,917	-	-	1,925,734
Illinois	9,582,663	620,171	39,696,088	-	381,894	50,280,816
Indiana	3,534,561	144,110	8,388,581	-	-	12,067,252
Iowa	1,284,389	-	2,448,193	-	-	3,732,582
Kansas	1,157,844	-	2,450,805	-	-	3,608,649
Kentucky	3,792,809	81,133	7,702,181	248,431	37,710	11,862,264
Louisiana	6,146,153	325,380	20,941,653	-	230,185	27,643,371
Maine	809,937	-	1,019,181	-	-	1,829,118
Marshall Islands	14,186	-	2,820	-	-	17,006
Maryland	9,216,519	-	29,800,019	-	495,233	39,511,771
Massachusetts	5,275,152	-	15,045,733	-	164,048	20,484,933
Michigan	5,082,352	252,343	12,996,772	-	167,224	18,498,691
Minnesota	1,963,514	125,795	5,976,431	-	55,377	8,121,117
Mississippi	6,219,673	-	7,533,479	264,670	115,526	14,133,348
Missouri	3,809,187	-	10,245,688	-	-	14,054,875
Montana	500,000	-	806,772	-	-	1,306,772
N. Marianas	50,000	-	7,276	-	-	57,276
Nebraska	1,247,191	26,047	2,505,306	-	13,762	3,792,306
Nevada	2,189,758	-	6,188,392	-	58,744	8,436,894

[174] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
New Hampshire	500,000	-	1,014,766	-	-	1,514,766
New Jersey	11,980,244	635,801	39,471,122	-	475,155	52,562,322
New Mexico	1,819,976	-	2,257,390	-	-	4,077,366
New York	39,859,230	2,357,778	119,859,704	631,961	1,790,541	164,499,214
North Carolina	11,245,753	407,253	27,069,633	271,217	325,667	39,319,523
North Dakota	500,000	-	255,423	-	-	755,423
Ohio	7,866,073	-	16,705,054	654,662	154,503	25,380,292
Oklahoma	3,618,532	-	4,717,089	200,990	-	8,536,611
Oregon	1,725,556	96,736	4,968,716	-	20,426	6,811,434
Pennsylvania	12,372,951	-	30,114,428	254,553	401,053	43,142,985
Puerto Rico	9,973,681	344,477	23,645,179	-	324,018	34,287,355
Republic of Palau	50,000	-	2,650	-	-	52,650
Rhode Island	1,360,398	-	2,570,166	218,929	27,159	4,176,652
South Carolina	11,224,926	230,894	14,015,418	335,153	193,498	25,999,889
South Dakota	500,000	-	730,845	-	-	1,230,845
Tennessee	5,364,347	276,756	17,757,870	-	174,166	23,573,139
Texas	21,625,309	1,168,879	64,616,560	-	776,127	88,186,875
Utah	1,709,161	38,481	3,208,987	-	-	4,956,629
Vermont	500,000	-	392,356	-	-	892,356
Virgin Islands	500,000	8,081	1,843,439	-	9,128	2,360,648
Virginia	7,539,290	384,466	22,978,977	361,424	244,988	31,509,145
Washington	3,610,260	199,838	11,684,909	-	61,277	15,556,284
West Virginia	1,061,758	-	1,488,804	-	-	2,550,562
Wisconsin	3,726,374	91,552	5,377,020	249,197	49,043	9,493,186
Wyoming	500,000	-	226,847	-	-	726,847
Total	**$334,254,067**	**$12,665,904**	**$943,401,151**	**$5,000,000**	**$10,234,501**	**$1,305,555,623**

Early Intervention Services – Part C

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$215,086,000	$206,431,000	$225,086,000	+$10,000,000
MAI (non add)	67,503,000	71,012,000	67,631,000	+128,000
SPNS	2,433,000	2,433,000	2,433,000	---
2011 World AIDS Day Initiative (non add)[175]	15,000,000	---	---	-15,000,000
Total Funding[176]	$217,519,000	$208,864,000	$227,519,000	+$10,000,000
FTE	34	34	34	---

Authorizing Legislation: Secs. 2651-67, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2014 Authorization……..……..…….…...Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part C of the Ryan White HIV/AIDS Program provides direct grants to community and faith-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the US Virgin Islands. Part C programs are the primary means for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in specific geographic communities, including rural and frontier communities. Part C programs target the most vulnerable communities, including people of color, men-who-have-sex-with men (MSM), women, and low-income populations. Part C programs have the cultural competency and expertise to provide care to these underserved and vulnerable populations. In 2010, seventy percent of those served by Part C clinics were people of color and 29% were female. Part C providers are central to the nation's HIV testing initiatives, providing HIV counseling and testing to more than 751,400 people in 2010. Additionally, the Part C grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan play an important role in implementation of the National HIV/AIDS Strategy through continued provision of HIV testing, care and treatment to those infected with HIV in the "Twelve Cities Initiative." This initiative is a key part of the HHS strategy to better coordinate HIV prevention, care, and treatment across HHS, state, and local partners.

The number of persons receiving primary care services under Early Intervention Services programs was 236,745 in FY 2007 and 247,133 in FY 2008. The 2009 results show 255,429 clients were served by the Early Intervention Services program. In 2010, 273,157 clients were

[175] This funding was a joint effort between the Ryan White and Health Center programs. Part C grantees received $9.911 million from the Ryan White Program and $5.089 million from the Health Center Program.
[176] Included in the FY 2012 total is $5.089 million from the Health Center Program's BA.

served by the Early Intervention Services program, exceeding that target by 32,491clients and representing an increase of 17,728 clients served compared to FY 2009.

Funding includes costs associated with FTEs, grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount[177]
FY 2005	$195,578,000
FY 2006	$193,488,000
FY 2007	$193,721,000
FY 2008	$198,754,000
FY 2009	$201,877,000
FY 2010	$206,383,000
FY 2011	$205,564,000
FY 2012[178]	$215,086,000
FY 2013	$206,431,000
FY 2014	$225,086,000

On World AIDS Day, December 1, 2011, the President announced an additional $15 million for Ryan White Part C grantees to support and expand care provided by HIV medical clinics across the country. In response to the President's announcement, total funding for Part C grantees in FY 2012 was increased by $15 million above the FY 2012 Part C appropriation, through a joint effort between the Ryan White HIV/AIDS Program and the Health Center Program.

Budget Request

The FY 2014 President's Budget Request for the Ryan White HIV/AIDS Part C Program of $225,086,000 is $10,000,000 above the FY 2012 Enacted Level. This request will support 357 Part C grantees/HIV medical clinics provide early intervention services, access to care, and primary care services for 268,877 people living with HIV/AIDS.

In FY 2014, many Part C grantees will be directly affected by the Affordable Care Act health insurance expansions as uninsured individuals living with HIV/AIDS begin to enroll in private health insurance or expanded Medicaid. In states and cities where the number of insured Ryan White clients begin to increase, Part C grantees will continue to provide services not covered by private or public insurance but which are 1) critical to providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking individuals living with HIV into care and started on ARV treatment as early as possible. Supporting interventions that get people linked into care and on medications is critical to preventing the spread of the epidemic as studies have found that treatment reduces HIV transmission by 96 percent.

[177] Excludes comparable amounts for SPNS.
[178] Reflects Ryan White BA only (does not include $5.089 million in Health Center Program BA for Part C grantees in FY 2012).

The FY 2014 target for the number of people receiving primary care services under Early Intervention Services programs is 268,877. Part C funding will also contribute to achieving the FY 2014 targets for the Ryan White HIV/AIDS Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, persons learning of their serostatus from Ryan White programs, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. *(Output)*	FY 2010: 273,157 Target: 240,666 (Target Exceeded)	257,053	268,877	11,824

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	357	357	357
Average Award	$556,130	$578,238	$630,492
Range of Awards	$121,875-$1,372,246	$122,000-$1,300,000	$122,000-$1,400,000

Women, Infants, Children and Youth – Part D

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$77,167,000	$77,639,000	$77,167,000	---
MAI (non add)	22,500,000	23,671,000	22,543,000	+$43,000
SPNS	902,000	902,000	902,000	---
Total Funding	$78,069,000	$78,541,000	$78,069,000	---
FTE	11	11	11	---

Authorizing Legislation: Sec. 2671, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2014 Authorization……Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Part D program focuses on providing access to coordinated, family-centered primary medical care and support services for HIV-infected women, infants, children, and youth (WICY) and their affected family members. It also funds support services, like case management and childcare that help clients get the care they need. Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Part D programs include community based organizations, hospitals, and State and local governments. Currently, there are 114 WICY programs in 38 states and Puerto Rico.

The Part D grantees play a role in implementation of the National HIV/AIDS Strategy through continued provision of care, treatment and support services for women, children and youth living with HIV/AIDS.

The number of female clients provided comprehensive services, including appropriate services before and during pregnancy, to reduce perinatal transmission in FY 2010 was 53,753 (age 13 and above). The number exceeded the FY 2010 target by 2,437 clients or 4.5%. In FY 2009, the Part D program provided comprehensive services, including treatment before and during pregnancy to reduce perinatal transmission, to 55,335 female clients. In FY 2008, 57,773 females received such services. In FY 2007, Part D programs provided services to 48,485 female clients. The results for FY 2007, FY 2008, and FY 2009 also exceeded the targets. The total number of clients served in Part D in FY 2010 was 79,594. This number includes 4,349 infants (ages 0-2 years), 7,264 children (ages 2-12 years), 18,567 youth (ages 13-24 years), and 49,357 persons ages 25 years and older. Of the 79,594 persons served in Part D in FY 2010, 75% were female and 25% were males, and less than 1% were transgendered or unknown/unreported. Seventy-six percent of all Part D clients served were HIV infected, with the remainder largely affected family members. Of the clients with known race and ethnicity, the majority (86%) were members of racial or ethnic minority groups.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount[179]
FY 2005	$72,519,000
FY 2006	$71,744,000
FY 2007	$71,794,000
FY 2008	$73,690,000
FY 2009	$76,845,000
FY 2010	$77,621,000
FY 2011	$77,313,000
FY 2012	$77,167,000
FY 2013	$77,639,000
FY 2014	$77,167,000

Budget Request

The FY 2014 President's Budget Request for the Ryan White HIV/AIDS Part D Program of $77,167,000 is equal to the FY 2012 Enacted Level. This request will support primary health care and social support services available to approximately 80,000 women, men, transgendered persons, infants, children, youth and adults living with HIV and AIDS and their affected families. In 2014, as the Affordable Care Act's health insurance expansions take effect, Part D grantees will play a key role in providing support and guidance for tens of thousands of Ryan White clients eligible to enroll in private health insurance or expanded Medicaid. Part D services, such as intensive case management, will be critical to helping newly ensured Ryan White clients get linked into and regularly access medical care and start on ARV treatment as early as possible. These types of services, which help people get linked into care and on anti-retroviral treatment, are critical to preventing the spread of the epidemic as studies have found that treatment reduces HIV transmission by 96 percent.

The FY 2014 target for the number of female clients provided comprehensive services through Part D, including appropriate services before or during pregnancy to reduce perinatal transmission, is 52,790. Part D funding will also contribute to achieving the FY 2014 targets for the Ryan White Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, HIV-positive women who receive anti-retroviral medications, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

[179] Excludes comparable amounts for SPNS.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
20.II.A.1 Number of female clients[180] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. *(Output)*	FY 2010: 53,753 Target: 51,316 (Target Exceeded)	49,802	52,790	+2,988

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	114	114	114
Average Award	$599,393	$602,000	$599,393
Range of Awards	$100,000-$2,260,049	$100,000-$2,270,000	$100,000-$2,260,049

[180] Female clients counted are age 13 and above.

AIDS Education and Training Programs – Part F

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$34,542,000	$34,753,000	$34,542,000	---
MAI (non add)	9,644,000	10,144,000	9,662,000	+18,000
Total Funding	$34,542,000	$34,753,000	$34,542,000	---
FTE	3	3	3	---

Authorizing Legislation: Sec. 2692(a), PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2014 Authorization……...….Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The AETC network includes 11 Regional Centers encompassing a network of more than 100 local performance sites; five National Centers; nine Telehealth Training Centers; and three Graduate Medical Education projects. AETCs offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care providers, including physicians, nurses, physician assistants, dentists and pharmacists.

AETCs provide a critical area of support for the National HIV/AIDS Strategy (NHAS) by increasing access to quality HIV/AIDS care through the provision of clinical HIV/AIDS training for providers who serve the most vulnerable and hard to reach populations. The clinical management of HIV/AIDS, particularly the use of highly-active antiretroviral therapy (HAART) is the central focus of training. This is increasingly important as the HIV epidemic expands in the United States with improved testing rates and prolonged survival. In addition, the number of trained HIV care professionals is projected to decrease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers will be vital to meet the NHAS goals of expanding access to quality HIV/AIDS care and treatment.

The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and Ryan White HIV/AIDS Program sites. AETC-trained providers are more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptorships and mini-residencies, on-site training and technical assistance. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet. Based in leading academic centers across the country, the AETCs use nationally recognized faculty and HIV researchers in the development, implementation, and evaluation of the education and training offered.

During the period July 1, 2009 through June 30, 2010, 52% of all providers participating in AETC training self-identified as racial/ethnic minorities or were providers with 50% of more of their caseload comprised of HIV-positive clients identified as racial/ethnic minorities.

Forty-three percent of the AETC program training interventions were provided to racial/ethnic minorities in 2007, and the 2008 results show 44% of those trained were racial/ethnic providers. The 2009 results show the AETC program training interventions comprised 43% racial/ethnic minorities which met the target. In 2010, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 42%, which missed the target by 1 percentage point.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2005	$35,051,000
FY 2006	$34,646,000
FY 2007	$34,701,000
FY 2008	$34,094,000
FY 2009	$34,397,000
FY 2010	$34,745,000
FY 2011	$34,607,000
FY 2012	$34,542,000
FY 2013	$34,753,000
FY 2014	$34,542,000

Budget Request

The FY 2014 President's Budget Request for the Ryan White HIV/AIDS AETC Program of $34,542,000 is equal to the FY 2012 Enacted Level. This request will support targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. The AETCs are an important part of the Ryan White HIV/AIDS Program and play a vital role in ensuring the highest quality of care among providers. HRSA will continue to prioritize for the AETCs interactive training that demonstrates effectiveness to change provider behavior. This funding will support the goal of 43% as the proportion of AETC training intervention participants that are racial/ethnic minorities.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
21.V.B.1: Proportion of AETC training intervention participants that are racial/ethnic minorities. *(Output)*	FY 2010: 42% Target: 43% (Target Not Met)	43%	43%	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	28	28	28
Average Award	$2,212,397	$2,212,397	$2,212,397
Range of Awards	$1-$4,424,793	$1-$4,424,793	$1-$4,424,793

Dental Reimbursement Program – Part F

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$13,485,000	$13,568,000	$13,485,000	---
FTE	1	1	1	---

Authorizing Legislation: Sec. 2692(b), PHS Act, as amended by P.L. 106-345, as amended by PL109-415, as amended by P.L.111-87.

FY 2014 Authorization……..……..Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The HIV/AIDS Dental Reimbursement Program provides access to oral health care for people living with HIV/AIDS by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in dental education institutions, the Dental Reimbursement Program improves access to oral health care for people living with HIV and trains dental and dental hygiene students and dental residents to provide oral health care services to people living with HIV. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion.

The Community-Based Dental Partnership Program supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental educations programs. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to people living with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

Dental Reimbursement Program

Programs	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Dental Reimbursement Program	$9,046,000	$9,102,000	$9,046,000
Community-Based Dental Partnership Program	$4,439,000	$4,466,000	$4,439,000

In FY 2011, the Dental Reimbursement Program (DRP) awards met 36.5% of the total non-reimbursed costs reported by 56 participating institutions in support of oral health care. These

institutions reported providing care to 37,194 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 2,954 individuals or 8.6%. This represents a 4% increase from FY 2010 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. In FY 2011, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 33.8% women, 57.66% minority. Therefore, the DRP served a higher proportion of women than the representation of women among all AIDS cases in the nation, as reported by CDC. CDC reports 23.5% of AIDS cases in 2010 were among women and 66.5% of AIDS cases were among racial/ethnic minorities.

In FY 2011, the Community Dental Partnership Program funded 12 partnership grants to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral health services. Community-Based Dental Partnership grants are intended for a period of up to three years.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2005	$13,218,000
FY 2006	$13,077,000
FY 2007	$13,086,000
FY 2008	$12,857,000
FY 2009	$13,429,000
FY 2010	$13,565,000
FY 2011	$13,511,000
FY 2012	$13,485,000
FY 2013	$13,568,000
FY 2014	$13,485,000

Budget Request

The FY 2014 President's Budget Request for the Ryan White HIV/AIDS Dental Service Program of $13,485,000 is equal to the FY 2012 Enacted Level and will support oral health care for people with HIV. This program will continue to support the reimbursement of applicant institutions, outreach to people with HIV/AIDS who need dental care, and continued efforts to improve service coordination among reimbursement recipients and other community-based health service providers. The FY 2014 target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 33,316.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
22.I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	FY 2011: 37,194 Target: 34,240 (Target Exceeded)	33,316	33,316	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	68	68	68
Average Award	$188,275	$189,427	$188,275
Range of Awards	$288-$389,948	$288-$392,334	$288-$389,948

Health Care Systems Tab

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Request	FY 2014 +/- FY 2012
BA	$24,015,000	$25,001,000	$26,015,000	+2,000,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by P.L. 108-216, P. L. 109-129 and P.L. 110-144, as further amended by P.L. 110-413

FY 2014 Authorization……...Expired

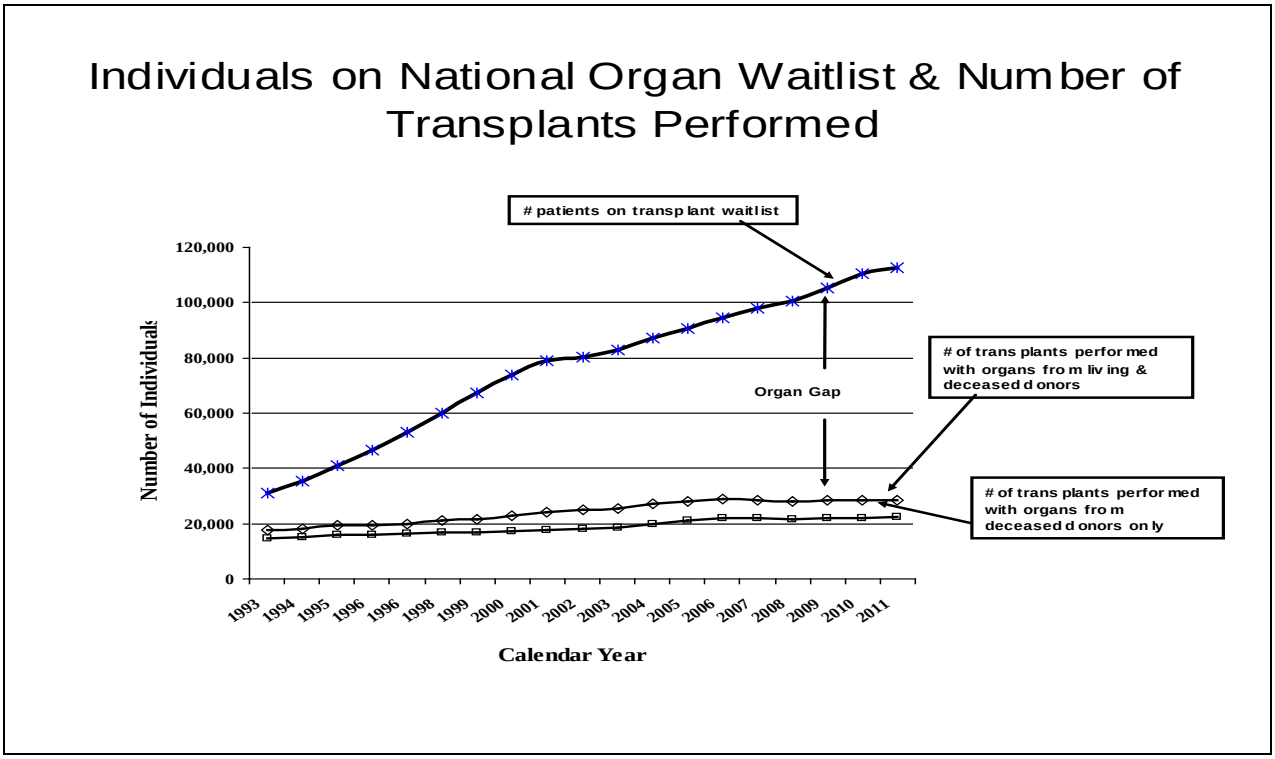
Allocation Method…….....Contracts/Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Organ Transplantation Program. The primary purpose of the Program is to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program works towards achieving this goal by providing for a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. The allocation of organs is guided by organ allocation policies developed by the OPTN with analytic support provided by the Scientific Registry of Transplant Recipients (SRTR). In addition to the efficient and effective allocation of donor organs through the OPTN, the Program also supports efforts to increase the supply of deceased donor organs made available for transplantation and to ensure the safety of living organ donation.

Ideally, an organ that provides optimal benefit would be available for every transplant candidate at the most appropriate time. Unfortunately, the demand for organ transplantation greatly exceeds the available supply of organs (see Figure 1). This trend is anticipated to continue, unless there is a major breakthrough in medical technology that will obviate the need for donor organs or the incidence of end-stage organ failure in the U.S. dramatically declines. At the end of 2011, there were 112,816 patients listed on the waiting list and 6,663 individuals died (approximately 18 per day) while waiting for a donor organ.

Figure 1. Individuals on National Organ Waitlist & Number of Transplants Performed



The Program goals are summarized by two overarching measures: (1) increase the annual number of deceased donor organs transplanted; and (2) increase the total number of expected life-years gained in the first five years after the transplant for all kidney and kidney-pancreas transplant recipients (from deceased donors) as compared to what would be expected for these recipients had they remained on the waiting lists.

The first goal of increasing the annual number of deceased donor organs transplanted is based on converting the number of 'eligible deaths' into actual donors (donor conversion rate). An 'eligible donor' is defined as any heart-beating individual meeting the criteria for neurological death, age 70 years or under, who has not been diagnosed with exclusionary medical conditions published by the OPTN. In 2011, 24,973 deceased donor organs were transplanted, 18 percent below the target of 30,515. However, it is a 1.5 percent increase above the 2010 result. In 2010, 24,598 deceased donor organs were transplanted, a two percent increase above the 2009 result. In 2009, 24,116 deceased donor organs were transplanted, a slight increase over the 23,933 deceased donor organs transplanted in 2008. Overall, the number of deceased organs transplanted in 2011 represents a 4.5 percent increase above the 2008 result.

The number of deceased donor organs made available for transplantation is primarily dependent on the number of eligible donors. Since 2002, the number of eligible donors has decreased. The number of eligible deaths in 2002 was in excess of 12,000. This number has steadily decreased to slightly above 9,000 in 2011. Improved prevention and treatment efforts have in part contributed to the decrease in the number of eligible donors. Fewer severe head traumas and improved management of brain injuries have resulted in fewer patients proceeding to brain death.

The National Highway and Safety Administration reports traffic accident deaths in 2010 fell to the lowest level ever in the U.S. since 1949. In 2008, the eligible deaths consisted of 3,281 head trauma deaths. In 2010, head trauma deaths decreased to 2,978. From 2008 to 2010, head trauma deaths made up approximately 33 percent of eligible deaths. Another reason for the decrease in the number of eligible deaths is that first-time cardiovascular events (resulting in anoxic brain injuries that may lead to brain death) have seen a 28 percent reduction in the event fatality rate since 1990 as a result of improvements in emergency and acute care. Hospital deaths have also been declining, which is congruent with the trend of the decreasing number of eligible deaths. Because of the decline in eligible donors, the Program has adjusted its FY 2013 and FY 2014 performance targets.

A major component of efforts to increase organ donation in the last decade was a series of Breakthrough Collaboratives that began in late 2003 to rapidly increase the number of deceased donors and number of donor organs made available for transplant through the sharing of best practices. Breakthrough Collaboratives apply a proven methodology, established by the Institute for Healthcare Improvement (IHI), to successfully generate and sustain improvements in healthcare systems. The first Collaborative, the Organ Donation Breakthrough Collaborative, was initiated in September of 2003 and established a goal of increasing the organ donation conversion rate from 52 percent in 2003 to 75 percent by FY 2013. While the number of eligible deaths has been decreasing, the donor conversion rate has increased steadily. The conversion rate was 66.5 percent in 2008, 69.1 percent in 2009, 71.2 percent in 2010, and 72.71 percent in 2011 representing a 39.8 percent improvement from the 52 percent baseline in 2003. Since the first Collaborative, the focus has changed over time to include efforts to improve: 1) the number of organs made available; 2) the capacity of organ procurement organizations (OPOs) and transplant centers to effectively manage more organ donors and perform more organ transplants; and 3) efforts to expand the use of other types of organ donors such as cardiac-death donors and expanded criteria donors.

HRSA has continued to invest in several activities to sustain and improve upon the gains of the Breakthrough Collaboratives. The umbrella for these activities is the "Organ Donation and Transplantation Community of Practice" (Community of Practice). The major focus of the Community of Practice is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The Community of Practice continues the "all teach, all learn" knowledge-sharing model through local and regional networks and interaction known as the Donation Service Area (DSA) Action Teams and Regional Collaboratives. The 58 DSAs are the areas served by each OPO. The Action Team consists of representatives of the OPO, donor hospitals, transplant centers, and in some cases, other partners in the donation process (e.g., eye and tissue banks, State hospital association members, donor registry professionals). Successful strategies at the DSA level are shared at the regional level – there are 11 regions designated by the OPTN in the U.S. These local (DSA) and regional efforts culminate in the National Learning Congress (NLC), HRSA's major event educating and recognizing organizations that have met national goals in increasing organ and tissue donation: 75 percent conversion rate, 3.75 organs transplanted per donor, and 10 percent of donors being donated after cardiac death. Through the NLC, best practices identified and refined through DSA action and regional strategies are shared nationally. Attendees include professionals from OPOs, hospitals, transplant centers, eye and

tissue banks, hospital associations, donor designation entities, and others. In addition, several topic-specific sharing and educational experiences are convened during the year.

Additionally, HRSA is seeking and sustaining partnerships with key organizations that touch the donation and transplantation processes, including entities with capabilities in professional development, healthcare, and public education. HRSA has implemented an education program to leverage web-based technological capabilities to better meet the educational needs of the community. HRSA has implemented programs to improve enrollment in donor registries, to educate healthcare professionals about honoring donor designation, and to increase support of potential donor families, all of which have an impact on conversion rate. Other programs share best practices in the medical management of organ donors to increase the number of organs that can be recovered from each donor. Maximizing donor potential is especially critical because more donors are being accepted under extended medical, age, and recovery criteria. HRSA contracted with the United Network for Sharing (UNOS) to conduct a study to estimate donor potential in the U.S. HRSA will use the results from this study and a donation-specific Gallup survey, scheduled to be completed in 2013, to refine the strategic approaches to maximize deceased donor potential, to increase the number of organs available for transplantation and to modify program performance measures.

The Program is making progress towards achieving its second long-term goal of increasing the total number of expected life-years gained in the first five years after the transplant for all kidney and kidney-pancreas transplant recipients (from deceased donors) as compared to what would be expected for these recipients had they remained on the waiting lists. The goal is to increase the total lifetime benefit achieved by all transplant recipients.

As with the first long-term goal of increasing the number of deceased donor organs transplanted, the life-years-gained goal has annual targets representing incremental marginal gain (i.e., the average number of life-years gained for each kidney transplant recipient) and the total number of expected life-years gained for all individuals receiving a kidney transplant in a given year. Therefore, achieving the long-term goal is dependent on the marginal improvement gained via each transplant performed, as well as by increasing the total number of kidney transplants performed.

In FY 2008, the average number of life-years gained per transplant was revised upward from 0.410 to 0.430 and the total expected life-years gained was revised upward from 4,586 years to 4,835 years. In FY 2009, the average number of life-years gained per transplant was revised upward from 0.420 to 0.430 and the total expected life-years gained was revised upward from 4,851 years to 4,868 years. In FY 2010, the Program fell short of its average number of life-years gained per transplant target (0.380 average, actual versus 0.427 average, target) and its total expected life-years gained (4,381 years, actual versus 6,213 years, target). In FY 2011, the average number of life-years gained per transplant was .340 and the total expected life-years gained decreased to 4,069 years compared to a target of 6,565 years.

The decrease in the average and total expected life-years gained in FY 2011 is because of improvements by transplant centers in prolonging the expected life-years for patients on the waitlist. This is likely related to improvements in dialysis management resulting in reductions in

relative waitlist death. While life-years gained on the waitlist have improved, the benefits of transplant in terms of life-years gained still exceed the increased life-years gained on the waitlist. Comparatively, in FY 2008, the average number of life-years gained on the waitlist was 4.05 years versus 4.48 years with a transplant. In FY 2009, the average number of life-years gained on the waitlist was 4.06 years versus 4.50 years with a transplant. In FY 2010, the average number of life-years gained on the waitlist was 4.14 years versus 4.53 years with a transplant. In FY 2011, the average number of life-years gained on the waitlist was 4.19 years versus 4.54 years with a transplant. In the last three years, the percent increase in life-years gained on the waitlist has more than doubled the percent increase in life-years gained with a transplant (3.46 percent versus 1.34 percent).

An important component of the total expected life-years gained is the number of kidney transplants performed. The main reason the performance goal was not met is because fewer than the projected number of deceased kidney transplants were performed in FY 2011. Increasing the marginal improvement gained by each kidney transplant may also be improved by revising how kidneys are allocated. Over the past several years, the OPTN has made incremental improvements to the kidney allocation policy. Even with these improvements, the current policy still places great emphasis on the amount of time individuals wait for an organ transplant as opposed to the differential clinical benefit which may be afforded for each individual waiting for a transplant. The OPTN is currently working on a new kidney policy that will place less emphasis on time on the waiting list and more emphasis on medical determinants that will seek to maximize benefit to the patient and maximize the use of deceased donor kidneys. Depending on the final construct of this allocation policy, which must balance many issues in addition to survival benefit, it is anticipated that this new policy will improve the expected five-year survival benefit post transplant.

Funding History

FY	Amount
FY 2010	$25,991,000
FY 2011	$24,896,000
FY 2012	$24,015,000
FY 2013	$25,001,000
FY 2014	$26,015,000

Budget Request

The FY 2014 Budget Request is $26,015,000. The FY 2014 Request is a $2,000,000 increase over the FY 2012 Enacted level. The increase over the FY 2012 level will be used to fund activities to evaluate and support the development of a national system for Kidney Paired Donation (KPD).

The FY 2014 Request will continue support for the Organ Transplantation Program in achieving the FY 2014 performance targets: transplant 25,014 deceased donor organs and achieve 4,433 expected life-years gained for the five year post-transplant period for kidney and kidney/pancreas transplants performed.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), and follow-up performance reviews. The EHB supports the Organ Transplantation Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The funding also includes IT investment costs to support the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

The following activities will be supported with the requested funding:

Contract to Operate the OPTN ($2.6 million) — The OPTN is the critical nexus between individuals needing an organ transplant and donor organs made available from deceased donors. Organ allocation policies developed by the OPTN prioritize the allocation of deceased donor organs to individuals waiting for an organ. The policies are under continual review and refinement to achieve the best outcomes for patients. Given the critical shortage of organs, these policies strive to achieve the maximum benefit for the recipient as well as make the best use of donor organs. HRSA utilizes a competitive contracting process to award the contract to operate the OPTN. The OPTN contract is a cost-share, cost-reimbursement contract. The costs of operation of the OPTN are funded with revenues generated by fees collected by the OPTN to register patients on the national donor waiting list and with appropriated funds. The Stephanie Tubbs Jones Organ Transplantation Authorization Act of 2008 (P.L. 110-426) authorizes appropriated funds up to $7 million annually for the operation of the OPTN. In FY 2013, HRSA will award a new competitive contract to continue the operation of the OPTN, which identifies several new priority activities, including implementation of an electronic organ labeling and transport tracking process, development of a living donor data registry, and adding oversight of vascularized composite allograft transplantation after regulatory approval. The projected cost of operating the OPTN in FY 2014 is approximately $37.5 million.

Activities to Evaluate and Support the Development of a National Kidney Paired Donation System ($2.0 million) — Prior to making a decision about implementing a national KPD system, HRSA will solicit public comment on the implications of establishing such a system under HRSA oversight. HRSA will also seek additional objective analysis of the optimal structure of such a system, and depending on the outcomes of these efforts, support preliminary KPD system implementation activities.

Contract to Operate the SRTR ($4.25 million) — The major purpose of the SRTR is to provide analytic support to the OPTN in the development and evaluation of organ allocation and other OPTN policies. Additionally, the SRTR provides analytic support to HHS, including the Advisory Committee on Organ Transplantation. In an effort to make information about the performance of the OPTN more widely available to the public, the SRTR publishes on the Internet organ transplant program risk-adjusted patient and graft outcomes and risk-adjusted organ procurement organization performance, including comparison of the actual versus expected number of donors and donor organs retrieved. HRSA has chosen to use a competitive

contracting process to award a cost reimbursement contract for this critical function. The existing contract is from September 2010 through September 2015 including option periods.

Efforts to Institutionalize Best Practices to Improve Organ Donation Processes and Outcomes ($3.6 million) — From 2003-2008, HRSA conducted a series of Breakthrough Collaboratives intended to identify and rapidly disseminate best practices to increase the number of organs available for transplantation. This series of frequent and intense sharing and learning experiences was effective in stimulating change in organ donation processes. The Donation and Transplantation Community of Practice (DTCP), established in 2009, is the method by which these successful practices are hardwired into organizational processes. The DTCP is a community-driven network of individuals and organizations whose missions are relevant to the donation process. Its scope reaches the full range of the donation continuum, from the declaration of intent to donate via donor registries to outcomes related to transplant patient and graft survival. The DTCP is focused on sustaining the drive to examine successful practices and integrating them into practice. Founded in principles of the Breakthrough Collaboratives, the DTCP incorporates an "all teach, all learn" knowledge-sharing model through local and regional interaction known as the DSA and Regional Action Teams, which represent the range of partners in the community. The 58 DSAs are the areas served by each OPO and are grouped into 11 regions. In 2011, HRSA initiated a formal partnership with a community organization to carry out activities of the DTCP via a cooperative agreement. Through this partnership, HRSA will continue to meet the needs of the community in a cost-effective manner through action-oriented and educational experiences, including conferences and leveraging technology in Internet-based learning. The DTCP is currently supported by a logistics contract and two cooperative agreements to provide for activity and consultant support.

Grants to Support Projects to Increase Organ Donation ($6.598 million) — HRSA awards three types of competitive, peer-reviewed grants to public and nonprofit private entities to test and replicate new approaches for increasing organ donation, promote public awareness about organ donation, and support development and improvements of State donor registries:

1) Social and Behavioral Interventions to Increase Solid Organ Donation grants implement and evaluate social and behavioral strategies to increase family and/or individual consent for donation.

2) Clinical Interventions to Increase Organ Procurement grants focus on clinical activities that begin after consent is determined or given at time of death and extend until transplantation. These donor-management-related activities influence whether a potential donor actually progresses to become a donor and the number and quality of organs that may be procured for transplantation.

3) Public Education Efforts to Increase Organ and Tissue Donation grants fund the implementation of public education strategies to increase organ and tissue donation as evidenced by increased enrollment in State donor registries or by other means.

Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation ($3.0 million) — This cooperative agreement, initiated

in FY 2006, is to provide reimbursement of travel and subsistence expenses to living organ donors in accordance with 42 U.S.C. 274f. The Regents of the University of Michigan (Michigan) received this cooperative agreement through a competitive grant cycle in both FY 2006 and FY 2010 to operate this Program. Michigan, in collaboration with the American Society of Transplant Surgeons, established the National Living Donor Assistance Center (NLDAC) to operate this national program. While the Program does not promote living organ donation and has no performance goals for increasing the number of living organ donors, this activity helps increase access to transplantation, particularly for individuals of lesser financial means. The number of applications for funding assistance increased by nearly 18 percent for the period of September 2011 through August 2012 (745 applications) over the period of September 2010 through August 2011 (881 applications). Overall, the total number of applications increased by more than 240 percent over the baseline period of October 2007 through August 2008 (257 applications). The Program facilitated 1,485 living donor transplants from October 2007 through August 2012. As of the end of August 2012, an additional 186 prospective living donors had been approved for reimbursement pending the organ donation procedures. The median household income for transplant recipients who received an organ facilitated by NLDAC is approximately $25,870 and the median household income for the donors is approximately $31,418. In FY 2014, HRSA will award a new cooperative agreement through a competitive grant cycle to continue the operation of the Program.

Activities to Support Public and Professional Education ($3.817 million) — The Program, independently and in collaboration with the organ donation and transplant community and other stakeholders, supports a variety of public and professional education and outreach efforts designed to increase organ donation. Included in this category are projects designed to educate various segments of the population using communication options appropriate to the message and audience including: public service announcements broadcast via electronic media, virtual meetings, webinars, printed materials, documentaries, educational programs for the classrooms, national organ donation events, and Web sites. HRSA will continue to support innovative strategies for outreach efforts to encourage public commitment to organ donation. The Program supports education initiatives and other activities in collaboration with the OPTN and with major medical and professional organizations that are influential in organ and tissue donation. These activities are designed to increase the number of organ donors and number of deceased donor organs made available for transplantation.

Advisory Committee on Organ Transplantation and Interagency Activities to Support Donation and Transplantation ($0.15 million) — The OPTN final rule (42 CFR ' 121.12) authorizes the creation of an Advisory Committee on Organ Transplantation (ACOT) to provide recommendations to the Secretary on issues related to organ donation and transplantation. The Program supports the activities of the ACOT including the logistics for periodic meetings and analytic requirements.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Request	FY 2014 +/- FY 2012
23.II.A.1: Increase the annual number of deceased donor organs transplanted.	FY 2011: 24,973 Target: 30,515 (Target Not Met)	31,979	25,014	-6,965
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list.	FY 2011: 4,069 Target: 6,565 (Target Not Met)	6,928	4,433	-2,495
23.II.A.8: Increase the annual conversion rate of eligible donors.	FY 2011: 72.71% Target: 70.80% (Target Exceeded)	72.90%	73.25%	+0.35% point

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	23	18	16
Average Award	$553,434	$619,083	$623,565
Range of Awards	$194,571-$3,237,178	$197,254-$3,158,975	$225,000-$3,000,000

National Cord Blood Inventory

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$11,887,000	$11,960,000	$11,887,000	---
FTE	4	4	4	---

Authorizing Legislation - Public Health Service Act, Section 379, as amended by Section 3, P.L. 109-129 as amended by P.L. 111-264

FY 2014 Authorization…….....$30,000,000

Allocation Method…….……..... ……Contract

Program Description and Accomplishments

The National Cord Blood Inventory (NCBI) Program, established through legislation renewed on October 8, 2010, is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units, as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program (the Program), which is authorized by the same law. Cord blood banks participating in the NCBI Program also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies.

Blood stem cell transplantation is potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

The tissue types of blood stem cell donors must be closely matched with those of their recipients in order for the transplant to be successful. Since tissue types are inherited, patients are more likely to find a closely matched donor within their own racial and ethnic group. However, due to the high rate of diversity in the tissue types of racial and ethnic minorities, especially African-Americans, racial and ethnic minorities are less likely to find a suitably matched adult marrow donor on the Registry of the Program. Because umbilical cord blood can be used with a less perfect match in tissue type between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack a suitably tissue-

matched relative and who cannot find an adequately matched unrelated adult donor through the Program. Minority patients, especially African-American patients, are especially likely to benefit from additional cord blood units. For these reasons, HRSA policy for the NCBI continues to emphasize increasing the number of cord blood units collected from minority donors.

In the early years of umbilical cord blood transplantation, the majority of transplants were performed for pediatric recipients because of the smaller number of blood stem cells present in cord blood relative to adult marrow. However, the introduction of multiple cord blood unit transplants and NCBI-led increases in the size of the cord blood inventory, including units with a larger concentration of blood stem cells, have increased the availability of cord blood for adult recipients. Consequently, in each fiscal year since FY 2008, the number of adult patients receiving cord blood transplants has surpassed the number of pediatric recipients.

The NCBI provides funds through competitive contracts for the collection and storage of qualified cord blood units by a network of cord blood banks in the U.S. Contract awards are made based on assessment of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of offerors, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original one-year base period of a contract, current performance including progress toward financial self-sufficiency and compliance with contract terms are carefully considered. Additionally, HRSA continues to place particular emphasis on the demonstrated ability of offerors to collect and bank significant numbers of cord blood units from African-American donors.

HRSA awarded six contracts to the first cohort of umbilical cord blood banks to collect for the NCBI in November 2006. Two additional banks were added in September 2007, and five more banks were added in FY 2008 through FY 2010. No new cord blood banks were added during the period FY 2011 – FY 2012. Currently, 13 banks hold NCBI contracts. As of September 30, 2012, 53,609 NCBI cord blood units were available through the Program (Table 1). An additional 18,161 units will be collected with funds already awarded through FY 2012. A cumulative total of 71,770 units of cord blood will be collected with all funds awarded during the period FY 2007 – FY 2012. We estimate that approximately 7,500 additional units will be collected with funds awarded in FY 2013.

During the first year of collections for the NCBI (FY 2007), four cord blood units from this then-very-small inventory were released for transplantation, with an additional 104 units released for transplantation during FY 2008. During FY 2009, 458 units were released for transplantation, 530 units were released in FY 2010, 690 units were released in FY 2011, and 714 were released in FY 2012 with many units currently under evaluation for use by patients in need of transplant (Table 2). The benefit of large volume units, such as those collected with HRSA funds, is demonstrated by the fact that all of the NCBI units released for transplantation have cell counts well above the levels generally available prior to implementation of the NCBI Program. Many recipients of these cord blood units, especially those patients whose ancestry is not from northwest Europe, had no well-matched adult donor. As the inventory continues to grow, the diverse units comprising the NCBI will serve an increasing number of patients from populations that have difficulty obtaining cells from a well-matched adult donor. Of the cord blood units

collected with funds awarded from FY 2007 - FY 2012, over 60 percent will be from racial and ethnic minorities.

The potential of cord blood to sharply increase access to transplantation is being realized in several ways. First, cord blood has accounted for about one half of the growth in transplants over the life of the NCBI Program, and 20 percent of all transplants facilitated through the Program during FY 2012 utilized cord blood. Multiple-unit transplants continue to rise, from approximately 21 percent of all cord blood transplants during FY 2007 to nearly 37 percent in FY 2012.

For minority patients, cord blood has been especially critical in increasing access to transplantation, with 33 percent of all cord blood transplants facilitated by the Program in FY 2012 being for minority patients. In comparison, only 29 percent of the cord blood transplants facilitated by the Program in FY 2007 were for minority patients. Regional studies in areas with diverse patient populations (e.g., New York City and Houston) have shown that the majority of adult patients receiving cord blood transplants lacked adequately matched adult donors; thus cord blood was their only chance for life-saving transplants.

In addition to directly growing the NCBI inventory, the support provided to NCBI-contracted banks has played an important role in stimulating the collection and banking of many other (non-NCBI) units. Typically, these cord blood units do not meet the minimum cell content threshold established for the NCBI. While these other units may not meet this threshold, they remain a suitable source of blood stem cells, especially for smaller patients where an acceptable cell dose can still be achieved using smaller units. Finally, NCBI banks have provided to researchers more than 29,000 non-NCBI units, for a wide variety of pre-clinical and clinical research.

Table 1. Cord Blood Collections

Fiscal Year	Cumulative Units Made Available[181]
2007	2,017
2008	11,870
2009	22,920
2010	34,744
2011	43,340
2012	53,609

[181] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, all of the units collected with funds from a given fiscal year will not be made available on the registry during that same fiscal year.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	NCBI Units Released for Transplantation
2007	4
2008	104
2009	458
2010	530
2011	690
2012	714

Funding History

FY	Amount
FY 2010	$11,957,000
FY 2011	$11,910,000
FY 2012	$11,887,000
FY 2013	$11,960,000
FY 2014	$11,887,000

Budget Request

The FY 2014 Budget Request is $11,887,000. The FY 2014 Request is equal to the FY 2012 Enacted level. This funding will be used to support progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation and will, therefore, increase the number of patients in all population groups who are able to obtain life-saving transplants. Cell dose and degree of match between patient and cord blood unit are both strongly associated with transplant outcomes. Therefore, a larger inventory of publicly available cord blood units also will contribute to improved patient survival after transplant because a growing inventory of high cell count cord blood units will allow better tissue matches between patients and cord blood units. We estimate funding at the requested level will support the collection and banking of approximately 7,500 additional cord blood units assuming an average price to HRSA of $1,500 per cord blood unit. This represents the same number of cord blood units as will be collected using FY 2012 funds. With the addition of these units, approximately 65,000 NCBI units will be available for searching patients through the C.W. Bill Young Cell Transplantation Program by the end of FY 2014.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Increase the cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI)	FY 2012: 81,779 Target: 62,500 (Target Exceeded)	62,500	86,000	+23,500
Increase the size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2012: 53,609 Target: 46,800 (Target Exceeded)	46,800	65,000	+18,200
Increase the annual number of NCBI cord blood units released for transplant	FY 2012: 714 Target: 650 (Target Exceeded)	650	730	+80

Contracts Awards Table
Size of Contracts

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Contracts	13	14	14
Average Contract	$844,330	$791,039	$785,825
Range of Contracts	$152,113 - $1,744,960	$200,000 - $3,000,000	$200,000 - $3,000,000

C.W. Bill Young Cell Transplantation Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$23,330,000	$23,473,000	$23,330,000	---
FTE	7	7	7	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Section 3, P.L.109-129, as amended by P.L. 111-264

FY 2014 Authorization……..$30,000,000

Allocation Method……..…….……Contract

Program Description and Accomplishments

The primary goal of the C.W. Bill Young Cell Transplantation Program (the Program) is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and umbilical cord blood. The Program works toward this goal by: (1) providing a national system for recruiting potential bone marrow donors; (2) tissue typing potential donors; (3) coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; (4) offering patient and donor advocacy services; (5) providing for public and professional education; and (6) collecting, analyzing, and reporting data on transplant outcomes. Blood stem cell transplantation is potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is their best treatment option. Often, the ideal donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

Per authorizing legislation renewed on October 8, 2010 (The Stem Cell Therapeutic and Research Reauthorization Act of 2010, P.L. 111-264), the C.W. Bill Young Cell Transplantation Program is the successor to the National Bone Marrow Donor Registry. While the scope of activities required of the Program is similar to that of its predecessor, the Program has expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, to include all allogeneic blood stem cell transplants as well as other therapeutic uses of blood stem cells. The Program is operated through four major contracts that require close coordination and oversight. The authorizing legislation also requires an Advisory Council at the Department level to provide recommendations to the Secretary and to HRSA on activities related to the Program.

The major components of the Program are: (1) a Cord Blood Coordinating Center responsible for facilitating transplants with blood stem cells from umbilical cord blood units (including HRSA-funded National Cord Blood Inventory units) and providing expectant mothers with

information on options regarding the use of umbilical cord blood (i.e., public donation, private storage, research and discard); (2) a Bone Marrow Coordinating Center responsible for recruiting adult potential donors of blood stem cells, especially from underrepresented ethnic and racial minority populations and for facilitating transplants with blood stem cells from adult donors; (3) a combined Office of Patient Advocacy and Single Point of Access to assist patients from diagnosis to survivorship, identifying the gaps in services and offering programs to help meet the needs of patients, and to enable physicians to search for and obtain a suitable blood stem cell product from an adult donor or cord blood unit; and (4) a Stem Cell Therapeutic Outcomes Database responsible for collecting outcomes data on related and unrelated donor blood stem cell transplants and implementing an approach to collecting data on emerging therapeutic uses of donated blood stem cells.

Contracts for all components of the Program are awarded through a competitive contracting process that emphasizes technical merit. Contract opportunities are announced nationally and proposals are evaluated by technical review committees composed of individuals with expertise in fields related to the Program. Funding decisions are made based on committee assessments of technical merit, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original base period of the contracts, HRSA considers contractor performance and compliance with contract terms. During FY 2012, four new infrastructure contracts were awarded. FY 2014 funds will be used to support the third year of contract activities for the Program.

Performance measures are incorporated into the contracts and monitored quarterly to ensure that the Program meets its three long-term goals related to: (1) increasing the number of blood stem cell transplants facilitated annually; (2) increasing the number of transplants facilitated annually for minority patients; and (3) increasing one-year post-transplant patient survival. The Program's long-term goals are supported by two annual measures: (1) the increase in the number of adult volunteer potential donors of minority race and ethnicity on the Registry; and (2) the decrease in the unit cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors. Additional performance standards are developed and monitored under each contract.

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. The Program exceeded all three of its FY 2010 long-term goals which were to: (1) facilitate 4,500 transplants (5,228 were facilitated); (2) facilitate 636 minority transplants (820 transplants for minority patients were facilitated); and (3) increase the rate of patient survival at one-year post-transplant from 62 percent in 2003 to 69 percent in 2010 (the current survival rate is 71 percent).

Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access to transplantation for patients from all populations. The Program continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to transplant for minority patients. Adding to the pool of potential adult volunteer blood stem cell donors also helps accomplish this goal. As of the end of FY 2012, more than 10.57 million potential adult volunteer donors were listed on the Program's registry. More than 2.88 million

(27 percent) of the 10.57 million potential adult donors listed on the Program's registry self-identify as belonging to a racial/ethnic minority group. This exceeded the FY 2012 goal of 2.66 million. The cost of tissue typing strongly influences the number of potential volunteer donors who can be recruited to the Program's registry. Reductions in the cost of typing make it possible to recruit more donors for a given level of funding. The FY 2014 cost for each donor's tissue typing will remain $40.81, the same level negotiated and achieved in FY 2012. Though the typing costs will remain the same, the level of tissue typing specificity continues to increase resulting in more rapid matching between potential donors and searching patients.

Funding History

FY	Amount
FY 2010	$23,517,000
FY 2011	$23,374,000
FY 2012	$23,330,000
FY 2013	$23,473,000
FY 2014	$23,330,000

Budget Request

The FY 2014 Budget Request is $23,330,000. The FY 2014 Request is equal to the FY 2012 Enacted level. This funding will be used to support the Program's ambitious performance target of having 3,050,000 adult volunteers from racially/ethnically diverse minority population groups listed on the Program's registry. These funds also will support the major Program components (Cord Blood Coordinating Center, Bone Marrow Coordinating Center, Office of Patient Advocacy, Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of funds will be used to recruit and tissue-type new donors. The Program will also continue: (1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; (2) assessing quality of life for transplant recipients; (3) working with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant; and (4) collecting data on emerging therapies using cells derived from bone marrow and umbilical cord blood. Importantly, FY 2014 funding will allow the Program to continue critical planning to respond to a radiation or chemical emergency that would leave some casualties with temporary or permanent marrow failure, and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
24.II.A.2: Increase the number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups.[182] (Outcome)	FY 2012: 2.88M Target: 2.66M (Target Exceeded)	2.66M	3.05M	+0.39M
24.1: Increase the number of blood stem cell transplants facilitated annually by the Program.[183] (Outcome)	FY 2010: 5,228 Target: 4,500 (Target Exceeded)	N/A	N/A	N/A
24.2: Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients.[183] (Outcome)	FY 2010: 820 Target: 636 (Target Exceeded)	N/A	N/A	N/A
24.3: Increase the rate of patient survival at one year, post- transplant.[183] (Outcome)	FY 2010: 71% Target 69% (Target Exceeded)	N/A	N/A	NA
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	FY 2012: $40.81 Target: $50.44 (Target Exceeded)	$50.44	$40.8l	-$9.63

[182] A long-term target was set for FY 2013.
[183] This is a long-term measure. After FY 2010, the next year for which there is a target is FY 2013.

Contracts Awards Table
Size of Contracts

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Contracts	6	6	6
Average Contract	$3,609,372	$3,717,873	$3,609,372
Range of Contracts	$2,253-$16,048,000	$20,000-$16,101,489	$20,000-$15,958,489

Poison Control Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$18,830,000	$18,945,000	---	-$18,830,000
Prevention Fund[184]	---	---	$18,830,000	+$18,830,000
Total PCP	$18,830,000	$18,945,000	$18,830,000	---
FTE	4	4	4	---

Authorizing Legislation – Public Health Service Act, Sections 1271-1274, as amended by Public Law 106-174, as amended by Public Law 110-377.

FY 2014 Authorization .....National Toll Free Number - $700,000

FY 2014 Authorization .....Nationwide Media Campaign - $800,000

FY 2014 Authorization .....Poison Control Center Grant Program - $28,600,000

Allocation Method ..... Contracts/Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) is authorized through Public Law 110-377, the Poison Center Support, Enhancement, and Awareness Act of 2008. The Program is legislatively mandated to fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services and connect callers to the poison center serving their area; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the 800 number.

The Poison Help Line, 800-222-1222, was established in 2001 to ensure universal access to Poison Control Centers (PCC) services. Individuals can call from anywhere in the United States (U.S.) and will be connected to the poison center that services their local area. The PCP maintains the number and provides translation services in over 150 languages. Services are also provided for the hearing impaired.

Through the nationwide Poison Help media campaign, the PCP has been working to educate the public about the 800 number and increase awareness of poison center services. In FY 2006, the percent of inbound call volume on the toll-free number was 66 percent. This has increased to 83.7 percent in FY 2012. In FY 2006, only 19 percent of national survey respondents were

[184] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

aware that PCC calls are handled by health care professionals. This increased to 25 percent in FY 2012, exceeding the long term target.

For over 50 years, PCCs have been our Nation's primary defense against injury and death from poisonings. Today there is a national network of 57 PCCs that provides cost effective, quality health care to the general public and health care providers alike across the entire U.S. including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. Twenty-four hours a day, seven days a week, health care providers and other specially trained poison experts provide poisoning triage and treatment recommendations at no cost to the caller. PCCs are not only consulted when children get into household products, but also when seniors and people of all ages take too much medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related callers to PCCs and health care professionals regularly consult PCCs for expert advice on complex cases. PCCs are a critical resource for emergency preparedness and response as well as for other public health emergencies.

According to the American Association of Poison Control Centers (AAPCC) in 2010, more than 3.9 million calls were managed by poison centers, an average of nearly 11,000 calls per day. Approximately 2.4 million poisonings were reported, 93 percent of all poisoning exposures occurred in people's homes, and 1.7 million unnecessary visits to healthcare facilities were avoided.

Multiple studies have demonstrated that accurate assessment and triage of poison exposures by poison centers save dollars by reducing severity of illness and death, and eliminating or reducing the expense of unnecessary trips to an emergency department.[1,2] Consultation with a poison center can also significantly decrease the patient's length of stay in a hospital and decrease hospital costs.[185,186,187,188] In fact, utilization of poison centers by health care facilities continues to increase, highlighting the increase in the severity of poisonings and the need for toxicological expertise in clinical settings.[189] It is estimated that every dollar invested in the poison center system saves $13.39 in medical costs and lost productivity, for a total savings of more than $1.8 billion every year. Of that $1.8 billion, the Federal government saves approximately $662.8

[185] Vassilev ZP, Marcus SM. Impact of a Poison Control Center on the Length of Hospital Stay for patients with Poisoning. J Toxicol Environ Health Part A. 2007; 70(2): 107-110

[186] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. (2006). The potential impact of poison control centers on rural hospitalization rates for poisonings. Pediatrics. 118(5), 2094-2100.

[187] Healthcare Cost and Utilization Project [HCUP] (2007). 2005 National Inpatient Sample. Rockville, MD: Agency for Healthcare Research and Quality, Department of Health and Human Services.

[188] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. The impact of poison control cents on poisoning-related visits to emergency departments, U.S. 2003. Am J Emerg Med. 2008.

[189] Bronstein AC, Spyker DA, Cantilena LR Jr, et al. 2011 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 29th annual report. Clin Toxicol (Phila). 2012;50:911-1164.

million in medical care savings and reduced productivity.[190] In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the PCCs is the collection of poison exposure and disease surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, and Substance Abuse and Mental Health Services Administration, use these data for public health surveillance, including timely identification, characterization, or ongoing tracking of outbreaks and other public health threats. In addition, many State health departments collaborate directly with poison centers within their jurisdictions. For example, States and Federal agencies used data from PCCs to monitor public health related to fungal meningitis, carbon monoxide exposures related to Hurricane Sandy, and laundry detergent poisonings. Additionally, the Office of National Drug Control Policy (ONDCP) and the Department of Justice's Drug Enforcement Administration (DEA) have used PCCs' data to monitor the rise in the abuse of synthetic drugs, support the Synthetic Drug Abuse Prevention Act of 2012, and formulate the National Drug Control Policy of 2012.

Additionally, PCCs provide public and health care provider education. PCCs' health educators actively work to change behaviors to reduce poisonings and promote awareness and utilization of poison center services in their communities. According to the CDC, in 2009, the most recent year in which data are available, unintentional poisoning was the second leading cause of unintentional injury deaths behind motor vehicle crashes. Among people 25 to 64 years old, however, unintentional poisoning was the leading cause of death. Ninety-one percent of unintentional poisonings were caused by prescription drugs, primarily opioid analgesics. These drugs were implicated in more poisoning deaths than heroin and cocaine combined. Among the actions outlined in the ONDCP's prescription drug abuse prevention plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis, are educating parents, youth, and patients about the dangers of abusing prescription drugs, educating prescribers about the safe and appropriate use of these drugs, and developing convenient and environmentally responsible medication disposal programs. PCCs are active partners in these efforts and both the PCCs and the PCP have participated in the National Prescription Drug Take Back events sponsored by the DEA. PCCs also provide training and programs in clinical toxicology for many different health care professionals to help clinicians better manage poisoning and overdose cases.

[190] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2011.

Funding History

FY	Amount
FY 2010	$29,250,000
FY 2011	$21,866,000
FY 2012	$18,830,000
FY 2013	$18,945,000
FY 2014	---
FY 2014 Prevention Fund	$18,830,000

Budget Request

The FY 2014 Budget Request is $18,830,000. The FY 2014 Request is equal to the FY 2012 Enacted level. Funding for the PCP will be used to support PCCs' efforts to prevent poisonings, provide treatment recommendations, and comply with accreditation requirements. PCCs primarily rely on State and local funding, as Federal funding accounts for less than 15 percent of total funding for the majority of PCCs. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Many State funded poison control centers have faced termination due to State budgetary shortfalls in recent years. Federal funding is necessary to help sustain the valuable nationwide PCC infrastructure, which enables PCCs to sustain their public health and toxico-surveillance efforts.

Ninety-five percent of PCCs are now accredited, up from 78 percent in 2001. Many centers have implemented strategic planning initiatives and business plans, and increased access to services through outreach and education programs. In FY 2014, the Program proposes to continue to support initiatives that focus on preventing poisonings, providing treatment recommendations, complying with operational requirements needed to attain or sustain accreditation and implementing leading practices that enhance the quality and accessibility of poison education, prevention, and treatment. The Health Resources and Services Administration (HRSA) will also use funding to maintain and promote the Poison Help Line, provide translation services for non-English speaking callers, and raise awareness of poison center services.

The Affordable Care Act

The FY 2014 Request funded by the ACA Public Health and Prevention fund will support the following:

Support and Enhancement Grant Program ($17.33 million): Grant funds will be used to continue supporting PCCs efforts to prevent poisonings, provide treatment recommendations, and comply with operational requirements needed to attain or sustain accreditation. This request also includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks (EHBs), and follow-up performance reviews, and Information Technology costs.

National Toll-Free Hotline Services and Promotion of Number and Services ($1.5 million): Ensuring access to PCCs through the national toll-free hotline is a critical public health service that improves the quality of healthcare. The Program will fund and manage the toll-free number. Funding will also be used to support translation services for non-English speaking callers. The FY 2014 Request will support the following:

As legislatively mandated, the Program will continue to fund the nationwide media campaign to educate the public and health care providers about poison prevention, poison control resources, and the national toll-free number. To that end, the Program will provide technical expertise in the development of the media campaign and will continue to raise awareness about poison prevention and the availability of the toll-free number among the general public, health care providers including pharmacists and 340B Drug Pricing Program participants. The FY 2014 target is to maintain the percent of all calls routed to the PCCs using the toll-free number at 75 percent. Additionally, the PCP aims to maintain the 71 percent of human poison exposure calls made to PCCs that were managed outside of a health care facility, as reported by the AAPCC. This will be a challenge because the U.S. is in the grip of an epidemic of prescription drug overdoses, which is increasing emergency room visits.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
25.III.D.3: Increase percent of inbound volume on the toll-free number. (Output)	FY 2012: 83.7% Target: 73.7% (Target Exceeded)	73.7%	75%	+1.3%
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. (Outcome)[191] (FY 2006 Baseline: 19%)	FY 2012: 25% (Target Not in Place)	N/A	N/A	N/A
25. III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a healthcare facility. (Output)	FY 2010: 71% (Baseline)	N/A	71%	N/A

[191] This is a long term measure. FY 2016 is the first year for which there is a target. The FY 2016 target is 25 percent.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	53[192]	53[193]	54[194]
Average Awards	$320,846	$320,132	$320,132
Range of Awards	$12,466-$2,013,064	$12,466-$1,957,186	$12,466-$1,957,186
Range of Contracts	$7,000-$255,000	$30,000-$300,000	$30,000-$300,000

[192] In FY 2012, there were 57 PCCs across the Nation. Fifty-three awards were made under the Support and Enhancement Grant Program, representing 56 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[193] In FY 2013, we expect that there will be 57 PCCs across the Nation. Fifty-three awards will be made under the Support and Enhancement Grant Program, representing 56 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[194] In FY 2014, we expect that there will be 57 PCCs across the Nation. Fifty-four awards will be made under the Support and Enhancement Grant Program, representing 57 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$4,472,000	$4,499,000	$4,472,000	---
FTE	3	3	3	---

Authorizing Legislation - Public Health Service Act, Section 340B as amended by Sections 7101-7103, P.L. 111-148, as further amended by Section 2302, P.L. 111-152, and as amended by Section 204, P.L. 111-309

FY 2014 Authorization…….……..…..SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

The 340B Drug Pricing Program (340B Program) requires drug manufacturers to provide discounts or rebates to a specified set of HHS-assisted programs and hospitals that meet the criteria in the Public Health Service Act and the Social Security Act for serving a disproportionate share of low income patients. The following health care providers are eligible to purchase outpatient drugs at 340B prices: all Health Resources Services Administration (HRSA)-assisted Federally Qualified Health Centers; Black Lung Clinics; Ryan White HIV/AIDS Programs including AIDS Drug Assistance Programs; Comprehensive Hemophilia Treatment Centers; Indian Health Service tribal organizations and Urban Indian Programs; Centers for Disease Control and Prevention-assisted sexually transmitted disease (STD) and tuberculosis (TB) clinics; Native Hawaiian Centers; Title X Family Planning Clinics; certain disproportionate share hospitals; children's hospitals; Federally Qualified Health Center Look-A-Likes; Free-Standing Cancer Centers; Critical Access Hospitals; Rural Referral Centers; and Sole Community Hospitals.

The 340B Program requires drug manufacturers to give covered entities a discount that is at least 23.1 percent below Average Manufacturer Price (AMP) for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. From FY 2010 through FY 2012, covered entities will save an estimated $3 billion on their $6 billion outpatient drug expenditures by participating in the 340B Program. The total savings in FY 2013 and FY 2014 are expected to increase as participation in the 340B Program increases. Drug purchases under the 340B Program represent approximately 2 percent of all U.S. drug purchases.

The Prime Vendor Program (PVP) established under Section 340B (a) (8) is responsible for the negotiation of pharmaceutical prices below the 340B ceiling price as well as contracting for wholesale distribution of pharmaceuticals to covered entities. The PVP is free and voluntary. The PVP contract was re-competed and awarded in 2009 to Apexus, a non-profit organization.

As of March 2012, the PVP had over 3,800 drugs under contract with an estimated average savings of 15 percent below the 340B ceiling price. In addition, the PVP has contracts for other value-added pharmacy products and services such as vaccines, diabetic supplies, pharmacy software, and outpatient pharmacy automation. Historically, the PVP contracts provided over $30 million in additional savings for covered entities enabling them to further expand their pharmacy programs and address growing patient needs during difficult economic times. Apexus has also established "shareback" payments of $4.5 million to participating covered entities. These funds allow the covered entities to purchase more medications at a reduced cost for their patients. The 340B Prime Vendor continues to build on the value that this public/private business arrangement brings to covered entities and the government. Current PVP trends are expected to continue, and savings are expected to increase substantially in subsequent years.

The technical assistance contract will provide assistance and expertise in the delivery of pharmaceutical services for the Office of Pharmacy Affairs and 340B covered entities. The two major areas of focus include (1) Program Integrity, Information, and Analysis and (2) Program Development.

Program Growth

By the end of FY 2012, over 18,215 covered entities sites were registered in the 340B Program. The 340B Program is expected to continue experiencing a three to four percent growth per year. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 9,846 pharmacies with 340B contracting arrangements and continues to grow since the final publication of guidance in March 2010.

Funding History

FY	Amount
FY 2010	$2,220,000
FY 2011	$4,480,000
FY 2012	$4,472,000
FY 2013	$4,499,000
FY 2014	$4,472,000

Budget Request

The FY 2014 Budget Request is $4,472,000. The FY 2014 Request is equal to FY 2012 Enacted level. From the inception of the 340B Program in 1992, the entire cost of administering the Program, including the development of guidelines and the provision of technical assistance to eligible grantees, has been borne by HRSA program management funds until FY 2009 when a line item of $1,470,000 was established. The line item was expanded to $2,220,000 in FY 2010 because of the need to make major improvements in program operations as identified by audits and evaluations conducted by the OIG. In addition, $1,584,000 of ACA funds was used to design systems and begin enrolling and supporting the five new eligible entity-types identified in ACA. FY 2011's line item was $4,480,000 and FY 2012 $4,472,000. Continued funding in FY 2014 is necessary to continue to oversee the 340B Program implement major improvements in

operations and to resolve identified deficiencies of the current level of operations. The areas of focus include:

Non-compliance with the 340B pricing requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data; omissions in data needed to compute 340B ceiling prices; and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. HRSA computes the 340B ceiling prices using data that manufacturers' supply to the Center for Medicare & Medicaid Services (CMS). Funds from the FY 2014 Request will continue to support the 340B pricing system, publication of policies regarding the computation of 340B ceiling prices, implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

Errors and omissions in HRSA's covered entity database - HRSA's staff and its contractors have continued to take a number of steps to improve the integrity, transparency, and reliability of the database of covered entities. This includes purging duplicate and obsolete entity records and adding updated entity information. While there have been great advances in improving the integrity and accuracy of the 340B database in response to deficiencies identified by the OIG, a sustained and systematic approach is needed to maintain this accuracy and integrity. HRSA will continue to require the verification of eligibility of entity types in FY 2014. In FY 2014, the continued administration of a systematic verification system will allow annual online verification of all records in the 340B database. HRSA considers the integrity of the 340B database to be a crucial responsibility that requires ongoing maintenance and development in order to effectively administer the 340B Program and meet the obligations of the Secretary and the law.

Program Regulations and Guidance - In FY 2014, HRSA will continue to support the implementation of program regulations and guidance to provide oversight to maintain the integrity of the 340B Program.

The 340B Drug Pricing Program funds the HRSA, Healthcare Systems Bureaus' Office of Pharmacy Affairs Information System (OPAIS) IT Investment. OPAIS is a multi-function web-based database system that provides information on covered entities, contract pharmacy arrangements, and manufacturers who have signed agreements with DHHS. This IT Investment supports the strategic and performance outcomes of the Program by facilitating access to clinically and cost effective pharmacy services among safety-net clinics and hospitals (known as the covered entities) that participate in the 340B Program.

Affordable Care Act

The ACA expanded the type of entities eligible for participation in the 340B Program to include children's hospitals, critical access hospitals, free standing cancer hospitals, rural referral centers, and sole community hospitals. Since August 2010, the Program has enrolled over 1,900 newly

eligible sites. They will continue to be enrolled as applications are made to the Program. In addition, new program integrity provisions were enacted which include civil monetary penalties, administrative dispute resolution, orphan drug exclusion, pricing transparency, and annual recertification for all covered entity types.

HRSA-Supported Performance Outcomes

The primary products are the 340B online public access database, required by legislation, for use by stakeholders of the 340B Program, and the pricing module to be used to validate manufacturers' calculations of the 340B ceiling price. This investment allows the Office of Pharmacy Affairs to improve its ability to respond to customer needs and improve 340B Program integrity. This project supports element 1.1 – to ensure accountability for business results by making sure stakeholders have accurate 340B Program data on which to base their sales projections or other business decisions.

In FY 2014, funding will be used to support the continued registration of the covered entity types eligible to participate in the 340B Program, with a target of 17,479 sites served.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
Covered Entity Sites Served	FY 2012: 18,215 Target: 15,996 (Target Exceeded)	15,996	17,479	+1,483
TA Consultations	FY 2011: 6,484 Target: 4,885 (Target Exceeded)	6,536	0[195]	-6,536

[195] The technical assistance contract awarded to provide technical assistance to 340B participants through a call center was ended on 9/30/2012. Currently, there is not a mechanism in place to capture this data.

Contracts Awards Table
Size of Contracts

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Contracts	2	2	2
Average Contract	$2,245,140	$2,245,140	$2,245,140
Range of Contracts	$1,490,000 – $3,000,000	$2,100,000 - $3,000,000	$2,100,000 – $3,000,000

Office of Pharmacy Affairs/340B Drug Pricing Program User Fees

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	---	---	$6,000,000	+$6,000,000
FTE	---	---	---	---

Authorizing Legislation - Public Health Service Act, Section 340B as amended by Sections 7101-7103, P.L. 111-148, as further amended by Section 2302, P.L. 111-152, and as amended by Section 204, P.L. 111-309

FY 2014 Authorization…….…….....SSAN

Allocation Method .....Contract

Program Description and Accomplishments

HRSA requires significant additional ongoing funding sources to be able to administer the new authorities and responsibilities. Funds are also needed to address long standing recommendations by the Office of Inspector General (OIG) and Government Accountability Office (GAO) to make major improvements in program integrity. The cost recovery fee provides the resources needed to address both long standing problems and the expanded authorities while reducing the government expenditure of taxpayer dollars.

The 340B cost recovery fee in FY 2014 is 0.1 percent (or one cent for every thousand dollars) of the total 340B drug purchases paid by participating covered entities. These funds shall be available until expended. The fee will be collected from the covered entities into a no-year account established by the Secretary for use by the Secretary and designees in administering operations of the 340B Program including integrity provisions and access to covered drugs and services for 340B eligible entities.

The administration of the cost recovery system will include the manufacturers periodic reporting to the Secretary. Reporting will include the purchases by entity under the 340B program and the establishment of the cost recovery fee as a percent of such drug purchases under the Program. The collected fee is in addition to the entity's cost to purchase the drug at the 340B price. This fee will be paid by and collected from the entity, through a mechanism established by the Secretary, and remitted to the Secretary. The Secretary will establish a mechanism to ensure that the full cost recovery fee is clearly identified and fully remitted to the Secretary as a condition of participation in the program. The calculation of the 340B price level is not affected by this provision. The 340B entities receive a significant benefit and the cost recovery fee is designed to ensure the cost of administering the Program is paid for with a small fraction of the received benefit. Without the cost recovery fee, the funding necessary to administer this Program comes exclusively from the taxpayers. The cost recovery fee will create a sustainable funding source

generated by those who benefit from the program to meet the demands of the existing growth of the Program, the changing marketplace, and the new statutory program requirements.

The FY 2014 cost recovery fee set at the 0.1 percent level, in addition to Office of Pharmacy Affairs' proposed line item budget, will fund the program's current and increased program integrity.

Program Growth

In FY 2012, approximately 1,900 newly eligible covered entity sites were registered in the 340B Program bringing the Program total to over 18,215 sites by the end of FY 2012. While the 340B Program is expected to continue experiencing a three to four percent growth per year for existing categories of eligible entities, the covered entities that are newly eligible are expected to increase at an accelerated rate of at least 10 percent for the first two to three years. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 9,846 pharmacies with 340B contracting arrangements and is expected to continue growing at an accelerated rate for the newly eligible covered entities. This is a result of the March 2010 publication of a Federal Register Notice allowing multiple contract pharmacy arrangements.

Funding History

FY	Amount
FY 2010	---
FY 2011	---
FY 2012	---
FY 2013	---
FY 2014	$6,000,000

Budget Request

The FY 2014 Budget Request is $6,000,000. The FY 2014 Request is $6,000,000 above the FY 2012 Enacted level. The 340B cost recovery fee system will establish the necessary requirements for manufacturers and covered entities to efficiently administer this cost recovery system that will provide operations, oversight and integrity for the 340B Drug Pricing Program. The cost recovery fee will support the natural growth of the 340B Program and fund new authority, responsibilities, and oversight. The Secretary will set the cost recovery fee at a rate up to 0.5 percent and can fully fund the operation of the Program at that level, therefore, eliminating the need for a line item appropriation. Implementation of these authorities will be phased in as regulations and policies are promulgated and systems are designed and implemented.

The cost recovery fee will ensure a reliable and continuous funding source for HRSA to fully administer the 340B Program and will allow HRSA to better monitor compliance among both manufacturers and covered entities. In anticipation of expected further growth of the Program and additional responsibilities relating to increased eligibility and maintaining integrity and

compliance, this funding mechanism will ensure the Program continues to operate successfully and effectively.

A legislative proposal has also been proposed to establish a sustainable 340B sales reporting process and a cost recovery fee mechanism to be collected from 340B participating entities for the purpose of administering Section 340B of the Public Health Service Act. The statutory change would ensure the cost recovery fee is both efficiently and effectively implemented. With statutory language, HRSA would have additional authority to enforce program requirements and implement the program integrity provisions as outlined by the OIG and GAO. The collected fee will be remitted to the Secretary for use in administering all operations of the Program including program integrity measures and providing access to covered drugs and services for 340B eligible entities. This amount would not affect the calculation of the entity's total acquisition cost of a 340B drug.

The cost recovery fee would address current information deficiencies as well as provide significant resources needed to address both long term goals to improve the program by addressing OIG requirements and the expanded statuary requirements of Affordable Care Act.

As stated in P.L. 111-148, HRSA is required to develop and implement a system to verify the accuracy of the 340B ceiling price in the marketplace. HRSA needs to develop and publish defined standards and methodology for the calculation of ceiling prices as well as put in place a new transparent system to calculate the official Federal 340B ceiling price and make it available to the covered entities through the secured internet website that protects proprietary pricing data. HRSA also needs to perform oversight activities such as spot checks of sales transactions by covered entities, selective auditing of manufacturers and wholesalers, inquire into the cause of any pricing discrepancies and take necessary corrective actions. The corrective actions include making sure the manufacturers issue timely refunds for routine retroactive adjustments and for exceptional circumstances such as erroneous or intentional overcharges. In addition, all covered entities are required to be recertified and their information updated on an annual basis or sooner to ensure the integrity of the system and information in the HRSA database is accurate.

Specifically, the user fee collected will cover the long-term goals of the Program that include expanded authority under Affordable Care Act and recommendations from the OIG and GAO. The areas of focus include:

Cost Recovery System – HRSA needs to develop and publish defined standards and methodology for the calculation of ceiling prices as well as put in place a new transparent system to calculate the official Federal 340B ceiling price and make it available to the covered entities through the secured internet website that protects proprietary pricing data.

Office of Pharmacy Affairs Information Systems (OPAIS) - Manufacturers are required to report their 340B ceiling prices directly to HHS. HRSA must develop a system of verifying ceiling price calculations, post 340B ceiling prices to a secure website, utilize spot checks of sales, and develop a system of refunds where appropriate. HRSA is required to establish a single, universal, and standardized identification system by which each covered entity site can be

identified by manufacturers, distributors, and covered entities for purposes of facilitating ordering, purchasing, and delivery of covered drugs, including the processing of charge-backs for such drugs. In addition, HRSA is required to make system improvements and add procedures to enable and require covered entities to regularly update the information via the internet website. The system will verify the accuracy of information regarding covered entities that are listed on the website.

Compliance and Oversight - Compliance issues are addressed primarily when they emerge as complaints from manufacturers, covered entities, or non-governmental interest groups. HRSA currently has no systematic method of monitoring manufacturer or covered entity compliance with the 340B law, P.L. 111-148, and HRSA's published guidelines. OIG reports on October 18, 2005, titled "Deficiencies in the Oversight of the 340B Drug Pricing Program (OEI-05-02-00072)"; and on July 14, 2006, titled "Review of 340B Prices (OEI-05-02-00073)" and the GAO report on September 23, 2011, titled "Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement" have outlined recommendations for program oversight and compliance. Among five recommendations to correct non-compliance among manufacturers, the OIG urged HRSA to institute oversight mechanisms to validate its 340B price calculations and the prices charged by manufacturers to participating entities. HRSA has not been able to fully implement these recommendations due to limited resources. The GAO report recommended selective audits of covered entities to ensure program compliance. With the limited resources currently available, HRSA has been unable to fully implement this compliance and oversight function.

Administrative Dispute Resolution Process - HRSA is authorized by P.L 111-148 to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased and claims by manufacturers of violations, including appropriate procedures for the provision of remedies and enforcement of such process through mechanisms and sanctions.

Civil Monetary Penalties - HRSA has new authority to impose sanctions in the form of civil monetary penalties for manufacturers and covered entities. HRSA will have the authority, under P.L. 111-148, to impose up to a $5,000 penalty to manufacturers for each instance of knowingly and intentionally overcharging a covered entity. In addition, HRSA will have the authority, under P.L. 111-148 to require covered entities to pay monetary penalties to manufacturers in the form of compounded interest for knowing of intentional violations of diversion and/or removing and disqualifying the covered entity from the 340B Program for a designated period of time as penalty when violations are found to be systematic and egregious.

Non-compliance with the 340B Pricing Requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data, omissions in data needed to compute 340B ceiling prices, and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. As a first step in correcting these problems, HRSA negotiated an intra-agency agreement with the Center for Medicare & Medicaid Services (CMS), permitting HRSA to compute the 340B ceiling prices using data that manufacturers supplied to CMS. Funds from the FY 2014 Request will continue to support publication of policies regarding the computation of

340B ceiling prices; implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

Outputs and Outcomes Tables

The Program measures are under development.

National Hansen's Disease Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$16,045,000	$16,143,000	$16,045,000	---
FTE	62	62	62	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Section 211 of the Public Law 105-78

FY 2014 Authorization .....Indefinite

Allocation Method .....Contract/Direct Federal/Intramural

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) has been providing care and treatment for Hansen's Disease (leprosy) and related conditions since 1921. The Program provides medical care to any patient living in the United States (U.S.) or Puerto Rico through direct patient care at its facilities in Louisiana, through funds to a Hansen's Disease Program in Hawaii and by contracting with 13 regional outpatient clinics and by providing cost free drug regimens, consultations, laboratory services and outpatient referral services as a safety net for private sector physicians (PSP) managing cases of Hansen's Disease. As of 2011, there are over 3,300 patients cared for through the NHDP's outpatient clinics and over 500 cared for by a PSP. The Program also provides training to health professionals, and conducts scientific research at the world's largest and most comprehensive laboratory dedicated to Hansen's Disease. The Program is the only dedicated provider of expert Hansen's Disease treatment services in the U.S. and a crucial source of continuing education for providers dealing with the identification and treatment of the disease in the U.S.

HRSA determined that NHDP would be better supported within the Healthcare Systems Bureau's (HSB) organizational structure. NHDP is a national health care infrastructure program, that provides education to health professionals to promote early detection and treatment, direct patient treatment, and research for disease prevention.

Increasing Quality of Care: Early diagnosis and treatment helps reduce Hansen's Disease-related disability and deformity. This can only be achieved if there are enough health care providers in the U.S. with knowledge of the disease and access to the support provided by the NHDP though its function as an outpatient clinic, training, education, and referral center. Increasing knowledge about Hansen's Disease in the U.S. medical community is expected to lead to earlier diagnosis and intervention, resulting in a decrease in Hansen's Disease-related disabilities. In FY 2012, the NHDP exceeded its program performance target of 150, and trained 202 private sector physicians.

Improving Health Outcomes: Hansen's Disease is a life-long chronic condition which left untreated and unmanaged will usually progress to severe deformity.

Through its focus on early diagnosis and treatment, the NHDP is monitoring its impact on improving health outcomes for Hansen's Disease patients through the prevention of increases in the percentage of patients with grades 1 or 2 disability/deformity[196]. In FY 2005, 51 percent of patients had grades 1 or 2 disability. In FY 2006 that figure was 46 percent, in FY 2007 that figure was 47 percent, and in FY 2008 the result was 45 percent, exceeding the target of 50 percent each year. In FY 2009 the result was 53 percent. This increase is attributable to an increased number of patients seen in 2009 and additional emphasis placed on conducting hand screens in the outpatient clinics. In FY 2010, 47 percent of patients had grades 1 or 2 disability, again exceeding our target.

The Program is also working to improve health outcomes through advances in Hansen's Disease research. The Program is measuring its advances in scientific knowledge through breakthroughs in genomic and molecular biology. The key performance measure examines the development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease. These markers and other progress will aid in the study of defective nerve function in infected armadillos which will ultimately permit development of a full animal model for human Hansen's Disease. In FY 2007, the Program met its target and developed the second of the 12 reagents (BRM-2) needed to produce a relevant animal model, as well as the first of six white blood cell subtype markers (CM-1). In FY 2008, the Program met its target and developed the third of the 12 reagents (BRM-3) needed to produce a relevant animal model, as well as the second and third of six white blood cell subtype markers (CM-2 and CM-3). In FY 2009, the Program met its target and developed BRM-4 and CM-4. In FY 2010, the Program demonstrated defective nerve function in infected armadillos. In FY 2011, the Program developed a "DNA fingerprint" to provide evidence to link leprosy transmission from armadillos to humans in the Southern U.S.

Promoting Efficiency: The NHDP outpatient care is comprehensive and includes treatment protocols for multi-drug therapy, diagnostic studies, consultant ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and patient transportation for indigent patients. The NHDP is committed to improving overall efficiency by controlling the cost of care at all of its outpatient clinics while keeping increases in the cost per patient served at or below the national medical inflation rate.

By restraining increases in the annual cost per individual served by the Ambulatory Care Program Clinics and at the NHDP's outpatient centers below the national medical inflation rate, the Program can continue to serve more patients that otherwise would have required additional

[196] Disability/deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation.

funding. In FY 2009, the cost per patient served through outpatient services was $1,088, reflecting a reduction of 12.5 percent of the target $1,676. In FY 2010, the cost per patient served through outpatient services was $1,142, reflecting an increase of 4.9 percent and slightly higher than the national medical inflation rate of 3.9 percent. In FY 2011, the cost per patient served through outpatient services was $1,057, a decrease of 7.4 percent, well below the national inflation rate of 4.13 percent.

Funding History

FY	Amount
FY 2010	$16,075,000
FY 2011	$16,077,000
FY 2012	$16,045,000
FY 2013	$16,143,000
FY 2014	$16,045,000

Budget Request

The FY 2014 Budget Request of $16,045,000 is equal to the FY 2012 Enacted level and reflects the change to Healthcare Systems Bureau. The entire FY 2014 Budget Request will support the Program's achievement of its performance targets. The Program will continue its goals in the area of increasing quality of care and improving health outcomes for Hansen's Disease patients.

A target for FY 2014 is to train 150 physicians, improving their knowledge and ability to diagnose and treat Hansen's Disease. A national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists, infectious disease and family practice physicians) is underway, as well as targeted efforts to train health care providers in Hansen's Disease where clusters of newly diagnosed cases are appearing.

In the area of Hansen's Disease disability/deformity prevention, it is expected that both the Program's existing case management efforts as well as its activities to train more private sector physicians to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients, maintaining the Grade 1 and Grade 2 levels of deformity at 50 percent. The Program's FY 2014 target for its research measure is to pursue a relevant animal model for human leprosy. The Program will also continue to promote efficiency by targeting in FY 2014 cost per patient increases below the national medical inflation rate.

The FY 2014 funding will support the Program's continued coordination and collaboration with related Federal, State, local, and private programs to further leverage and promote efforts to improve quality of care, health outcomes, and research related to Hansen's Disease.

Areas of collaboration include a partnership with the Food and Drug Administration (FDA) Drug Shortage Program to distribute the clofazimine to over 500 providers nationally. At the request of the FDA, the Program has also agreed to manage the investigational new drug (IND)

application that makes clofazimine available in the U.S. for treatment of leprosy. The NHDP has recently entered into collaboration with the Centers for Disease Control (CDC), to develop training and educational material for healthcare providers in the Western Pacific Islands.

The Program is the sole worldwide provider of reagent grade viable leprosy bacilli, and continues to collaborate with researchers worldwide to further the study of and scientific advances related to the disease. To support the Program training initiative of increasing the awareness of leprosy in the U.S. the Program has facilitated outpatient management of leprosy in the U.S. by providing to private sector physicians additional laboratory, diagnostic, consultation and referral services.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
3.E.: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (Efficiency)	FY 2011: -7.4% Target: Below national medical inflation rate Target: 4.13% (Target Exceeded)	Below national medical inflation rate	Below national medical inflation rate	Maintain
3.II.A.2.: Number of private sector physicians who have received training from the NHDP (Output)	FY 2012: 202 Target: 150 (Target Exceeded)	150	150	Maintain
3.II.A.3.: Number of patients provided Hansen's Disease outpatient care through the NHDP (Output)	FY 2011: 3,311 Target: 3,000 (Target Exceeded)	3,000	3,000	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
3.III.A.1.: Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease (Output)	FY 2011: Leprosy Link Demonstrated Target: Use DNA evidence to link leprosy transmission from armadillos to humans. (Target Met)	Pursue the integration of BRM, CM, and molecular reagent breakthroughs	Pursue relevant animal model for human leprosy	N/A
3.II.A.1.: Percent increases in the level of Hansen's Disease related disability and deformity among patients treated and managed by the NHDP (Percentage of patients at Grades 1 and 2)	FY 2010: 47% Target: 50% (Target Exceeded)	50%	50%	Maintain

Program Outputs

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
NHDP Resident Population	15	15	15
NHDP Non-Residential Outpatients	177	177	177
Ambulatory Care Program (ACP) Clinics	13	13	13
ACP Clinic Patients (Outpatients)	3,000	3,000	3,000
ACP Clinic Patient Visits	16,000	16,000	16,000
NHDP Non-Residential Outpatient Visits	22,000	22,000	22,000

National Hansen's Disease Program by Sub – Activity

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Administration	$ 1,446,000	$ 1,558,000	$ 1,460,000
Clinical Care	5,514,000	5,743,000	5,743,000
Regional Centers	2,498,000	2,428,000	2,428,000
Research	2,635,000	2,562,000	2,562,000
Facility Operations	2,535,000	2,446,000	2,446,000
Assisted Living Allowance	1,417,000	1,406,000	1,406,000
Total	$16,045,000	$16,143,000	$16,045,000

National Hansen's Disease Program – Buildings and Facilities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$127,000	$130,000	$127,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2014 Authorization ..... Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

This activity provides for the renovation and modernization of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana, to eliminate structural deficiencies under applicable laws in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. The projects are intended to assure that the facility provides a safe and functional environment for the delivery of patient care and training activities; and meets requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2010	$129,000
FY 2011	$127,000
FY 2012	$127,000
FY 2013	$130,000
FY 2014	$127,000

Budget Request

The FY 2014 Budget Request of $127,000 is equal to the FY 2012 Enacted level. The total request is required for continued renovation and repair work on patient areas, to complete minor renovation work on the Carville museum, and to continue regular renovation and repair work on clinic areas and offices.

Outputs and Outcomes Tables

See National Hansen's Disease Program.

Payment to Hawaii

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,960,000	$1,972,000	$1,960,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Section 211 of Public Law 105-78

FY 2014 Authorization ..... Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

Payments are made to the State of Hawaii for the medical care and treatment of persons with Hansen's Disease (HD) in its hospital and clinic facilities at Kalaupapa, Molokai, and Honolulu. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Funding History

FY	Amount
FY 2010	$1,976,000
FY 2011	$1,964,000
FY 2012	$1,960,000
FY 2013	$1,972,000
FY 2014	$1,960,000

Budget Request

The FY 2014 Budget Request of $1,960,000 is equal to the FY 2012 Enacted level.

Program Outputs

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Average daily HD Kalaupapa patient load	17	17	17

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Total Kalaupapa and Halemohalu patient hospital days	2,944	2,944	2,944
Total Kalaupapa homecare patient days	2,629	2,629	2,629
Total Hawaiian HD Program outpatients	272	272	272
Total outpatient visits	6,978	6,978	6,978

Rural Health

Tab

Office of Rural Health Policy

Summary of the Request

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$138,172,000	$140,421,000	$122,232,000	-$15,940,000
FTE	9	9	7	-2

Established in 1987, the Office of Rural Health Policy (ORHP) serves as a focal point for rural health activities within the Department. The Office is specifically charged with serving as a policy and research resource on rural health issues as well as administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

ORHP advises the Secretary and other components of the Department on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities. The Department has maintained a significant focus on rural activities for more than 21 years. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities.

There are nearly 50 million people living in rural America who face ongoing challenges in accessing health care.[197] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[198] Rural areas also continue to suffer from a shortage of diverse providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts.[199,200] Of the 2,052 rural counties in the United States (U.S.), 1,582 (77 percent) are primary care health professional shortage areas (HPSAs).[201]

The ORHP Programs (excluding the Radiation Exposure Screening, Black Lung, and Telehealth Programs) have two annual performance measures representing rural health activities as reflected in the Rural Health Services Outreach Grant Program and Rural Hospital Flexibility Grant

[197] Population and Percent Distribution by Core Based Statistical Area (CBSA) Status for the United States, Regions, and Divisions, and for Puerto Rico: 2000 and 2009 (CBSA-EST2009-11).
[198] Economic Research Service (August 2009). Health Status and Health Care Access of Farm and Rural Populations. Economic Information Bulletin Number 57. Washington, D.C. U.S. Department of Agriculture.
[199] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.
[200] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[201] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009.

Programs. The Rural Health Care Services Outreach Program provided both direct and indirect services for 2,451,969 individuals in FY 2009, which exceeded the target of 828,360. This is a substantial improvement from FY 2006 in which 627,120 individuals were served. This measure was revised to examine the increase in the number of people receiving direct services through the Outreach grant. This measure focuses on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, and, thus, more accurate. In FY 2011, 615,849 people received direct services through this program, exceeding the target of 385,000 people.

The Rural Hospital Flexibility Grant Program is helping to improve the quality of care at Critical Access Hospitals (CAHs). The CAHs are exempt from the Centers for Medicare and Medicaid Services (CMS) requirement for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys; however, patient satisfaction is an important component of hospital operations. Improved patient satisfaction can lead to improved reputation of the hospital within the community, which can lead to increased volume of services for the patients, increasing market share, when patients opt to stay in the community for care versus travel to a further hospital and reduced malpractice claims. In 2008, there were 34 percent of CAHs reporting on HCAHPS, in FY 2009 it increased to 35 percent and increased again to 38 percent in FY 2010.

Improving Rural Health Initiative

The goal for the President's "Improving Rural Health Care Initiative" is to build healthier rural populations and communities through evidence-based practices. The Office of Rural Health Policy (ORHP) will improve the coordination of rural health activities within Health Resources and Services Administration (HRSA), across the Department of Health and Human Services (DHHS), as well as other Federal Departments by leveraging rural health funds to improve the health of rural populations. Approximately $77 million of the total amount requested for the ORHP supports the President's initiative to improve rural health; specifically $55,553,000 from Rural Health Care Services Outreach; $10,036,000 from the State Offices of Rural Health; and $11,502,000 from Telehealth.

The goal of the initiative is to improve the access to and quality of health care in rural areas. To achieve this goal, the initiative focuses on five activities:

- Strengthening rural health care infrastructure;
- Improving the recruitment and retention of health care providers in rural areas;
- Building an evidence base for programs that improve rural community health;
- Providing direct health care services; and
- Improving the coordination of rural health activities within HRSA, DHHS, and across the Federal Government.

Affordable Care Act

The Affordable Care Act presents opportunities to provide comprehensive care and services to individuals who otherwise cannot afford or gain access to care by extending health insurance coverage and improving coordinated care. The HRSA Rural Health programs and activities do not have any direct funding from the Affordable Care Act, but may be affected by the expansions to comprehensive services and insurance coverage. In the out-years, some Rural Health programs, entities and activities may generate cost-savings from increased health insurance coverage. The FY 2014 request reflects our continued effort to carryout program mission and activities while assessing the impact of ACA on program capacity and services.

In addition, the ORHP continues to collaborate with HHS agencies and other Federal Departments to achieve the activities in the President's Improving Rural Health Care Initiative.

The following four programs within the ORHP support these five activities.

Rural Health Care Services Outreach, Network, and Quality Improvement

The Rural Health Outreach authority includes a range of programs designed to improve access to care, coordination of care, integration of services and to focus on quality improvement in health care for rural communities. These programs are among the only non-categorical grants within DHHS, which allows grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing local health concerns. The broad non-categorical nature of the programs also allows ORHP to focus funding on key emerging needs. For example, in the first couple of years of the Improving Rural Health Care Initiative, ORHP was able to focus funding on two key areas of need through funding of Network Development grants. The first focused on health care workforce development in 2010; the second on the adoption of health information technology in 2011. ORHP awarded 20 awards in the workforce development program and plans to conduct a short-term and long-term evaluation to ultimately determine the number of students who end up practicing in rural. The program focuses on a range of disciplines including mental health, dental, pharmacy, allied health, including primarily physician assistants, nursing and residency programs. In addition, ORHP awarded 41 health information technology grants in 2011 to adopt HIT and to reach meaningful use stage 1 and 2. ORHP will evaluate this program as well to understand lessons learned when the program ends in 2015. These programs help to improve access to and the quality of health care in rural areas by supporting three of the initiative's five components: strengthening rural health care infrastructure, providing direct health care service, and improving the recruitment and retention of health care providers in rural areas.

State Offices of Rural Health Grants

This program provides funding to the State Office of Rural Health located in each state to provide technical and other assistance, information dissemination to rural health providers and helps rural communities recruit and retain health care professionals. This program also supports

improving the recruitment and retention of health care providers in rural areas component of the initiative.

Rural Training Track Technical Assistance Grant-New Program for Rural Physician Training Grants

This pilot program provides technical assistance to new and established 1-2 Rural Training Track (RTT) family medicine residency programs in which the first year of training takes place in urban-based locations and the second and third years of residency occur in rural locations. The technical assistance is provided to help RTT programs across the Nation expand residency training and ultimately physician practice in rural areas; increase the number of medical students that match to RTT residency programs; and work with rural communities that have an interest in creating new programs. There are currently 23 active programs and, pending successful accreditation, eight new programs are scheduled to open within the next two years. This initiative also supports the "recruitment and retention of health care providers in rural areas" component of the initiative.

Telehealth Grants

This program expands the use of telecommunications technologies within rural areas that can link rural health providers with specialists in urban areas, thereby increasing access and the quality of healthcare provided to rural populations. Telehealth technology also offers important opportunities to improve the coordination of care in rural communities by linking rural health care providers with specialists and other experts not available locally. These grants support the initiative by strengthening rural health care infrastructure.

Coordinating Programs for a Targeted Investment

The programs listed above support the initiative. In addition, ORHP will use the existing funds to conduct program evaluations and build an evidence base for new ways to improve health care in rural communities. Evaluations will focus on measuring:

- The program impact on the health status of rural residents with chronic conditions such as diabetes, cardiovascular disease, and obesity;
- The return on investment for rural grantees and communities; and
- The economic impact of the Federal investment in rural communities.

The initiative will also identify successful models, lessons learned and common challenges faced by rural grantees. These best practices will be disseminated across the Nation as models that can be replicated.

Finally, as part of the initiative, ORHP will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, DHHS, and across the Federal Government. This will include increasing rural participation in health professional training and service programs in Title VII and VIII of the Public Health Service Act as well as the National

Health Service Corps. In 2010, ORHP began working collaboratively with the Department of Agriculture on a variety of issues ranging from defining frontier communities to coordinating telehealth and broadband access. The ORHP expanded its work with the Department of Veteran Affairs in 2011 while also reaching out to work collaboratively with the Department of Labor, Education and Transportation.

Funding History

FY	Amount
FY 2010	$184,910,000
FY 2011	$137,568,000
FY 2012	$138,172,000
FY 2013	$140,421,000
FY 2014	$122,232,000

Budget Request

The FY 2014 Budget Request is $122,232,000. The FY 2014 Request is $15,940,000 below the FY 2012 Enacted level. This request will fund the following rural health activities:

- $55,553,000 for the Rural Health Care Services Outreach, Network, and Quality Improvement Programs, which is equal to the FY 2012 Enacted level. This funding will continue to support key activities for Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs. One of the goals of the Improve Rural Health Initiative is to help existing rural networks improve the coordination of health services in rural communities and strengthen the rural health care systems as a whole. This effort supports that goal. The ORHP expects that 400,000 people will receive direct services in FY 2014.
- $9,866,000 for Rural Health Policy Development, which is equal to the FY 2012 Enacted level. Funding will support activities such as the rural health research center grant program as well as policy analysis and information dissemination activities on a range of rural health issues. The FY 2014 target for these activities is 35 reports.
- $26,200,000 for Rural Hospital Flexibility Grants. This request provides funding for the Rural Hospital Flexibility Program, which provides grants to support a range of activities focusing on CAHs. The activities supported through this funding will continue to support efforts by CAHs to report quality data to Hospital Compare. In FY 2010, 72.6 percent of CAHs reported at least one measure to Hospital Compare. The FY 2014 target for this activity is 85 percent.
- $10,036,000 for the State Offices of Rural Health Grants, which is equal to the FY 2012 Enacted level. This funding will continue to support key activities for the State Offices of Rural Health (SORH) Program and will support a grant award to each of the 50 states. It is part of HRSA's Improve Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain health care professionals. The SORH Program anticipates that it will provide 67,601 technical

assistance encounters directly to clients in FY 2014. The program also expects 22,408 clients (unduplicated) will receive technical assistance directly from SORHs in FY 2014.

- $1,935,000 for Radiation Exposure Screening and Education Program (RESEP), which is equal to the FY 2012 Enacted level. The purpose of this program is to provide grants to States, local governments, and appropriate health care organizations to support programs for individual cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. This program expects to screen 1,400 individuals in FY 2014.

- $7,140,000 for Black Lung Clinics, which is equal to the FY 2012 Enacted level. The purpose of this program is to commit funds through project grants for establishing clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and other with occupation-related respiratory and pulmonary impairments. This program expects to serve 12,840 miners in FY 2014.
- $11,502,000 for the Telehealth Grants, which is equal to the FY 2012 Enacted level. The funds will support: (1) Telehealth Network Grant Program grantees (26 grants, including grants to specifically examine the cost-effectiveness of telehomecare and tele-monitoring services); (2) Telehealth Resource Center Grant Program grantees (up to 13 grants); and (3) the Licensure Portability Grant Program (one grant), as well as associated technical assistance and evaluation activities. Funds will also be allocated to continue to support the Telehealth Technology Assessment Center. It is expected that the proportion of diabetic patients enrolled in a Telehealth diabetes management program will be 30 percent by FY 2014 for the FY 2012-2015 cohort.

The request includes no funding for the Rural and Community Access to Emergency Devices or for the Small Hospital Improvement Program.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.[202] (Outcome)	FY 2010: 14.2% Target: 13.9% (Target Not Met)	N/A	N/A	N/A
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome)	FY 2011: 615,849 Target: 385,000 (Target Exceeded)	390,000	400,000	+10,000
27.2: Increase the proportion of critical access hospitals with positive operating margins. [203] (Outcome)	FY 1999: 10% Target: N/A (Baseline)	N/A	N/A	N/A

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	380	360	360
Average Award	$175,000	$175,000	$175,000
Range of Awards	$75,000-$640,000	$75,000-$640,000	$75,000-$640,000

Grant Awards Table - Telehealth
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	40	40	38

[202] This is a long-term measure with FY 2013 as a long-term target date. FY 2010 was an earlier long-term target date to be reported in FY 2012.
[203] This is a long-term measure with FY 2013 as a long-term target date.

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Average Award	$262,195	$262,195	$262,195
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

Rural Health Policy Development

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$9,866,000	$9,926,000	$9,866,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 301 of the Public Health Service Act, Section 711 of the Social Security Act.

FY 2014 Authorization .....Indefinite

Allocation Method .....Competitive Grant

Program Description and Accomplishments

Rural Health Policy Development activities are a key component of the Office of Rural Health Policy (ORHP) and support a range of policy analysis, research and information dissemination. The Office is charged in its authorizing language to advise the Secretary on how Departmental policies affect rural communities and to conduct research to inform its policy analysis activities. The Office is also charged with supporting information dissemination and the operation of a clearinghouse on national rural health initiatives.

The ORHP Rural Health Research Center Grant Program is a major component of Rural Health Policy Development activities. It is the only Federal research program specifically designed to provide both short- and long-term policy relevant studies on rural health issues. Grants are awarded to six research centers annually. In the past, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about the rural population and the impact of Federal policies and regulations on the rural health care infrastructure. The work of the centers is published in policy briefs, academic journals, research papers, and other venues and is made available to policy makers at both the Federal and State levels. In addition to the research center grants, the Rural Health Policy Development Activities also support two additional cooperative agreements that focus on data and trend analysis on new and ongoing policy issues. These agreements are used to support data needs across the Department.

Another major component of Rural Health Policy Development is the Office's work in staffing the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural health and human service programs and policies and produces an annual report on critical rural issues for the Secretary.

Rural Health Policy Development also plays an important role in serving as a broker of information on rural health issues through a cooperative agreement with the Rural Assistance Center (RAC). In keeping with the statutory mandate, the office established the RAC as a clearinghouse for anyone in need of rural health policy and program information. The RAC responds individually to hundreds of inquiries each month by both phone and e-mail and disseminates information through its web site and various reports and information guides on a range of key rural health issues.

In FY 2011, the program produced 57 research reports, exceeding last year's results and the target of 30 reports. Of the 57 reports produced, 30 were predetermined research report for FY 2011. The remaining 27 reports were ad-hoc policy briefs, manuals and the completion of past-due reports.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$9,929,000
FY 2011	$9,885,000
FY 2012	$9,866,000
FY 2013	$9,926,000
FY 2014	$9,866,000

Budget Request

The FY 2014 Budget Request is $9,866,000. The FY 2014 Request is equal to the FY 2012 Enacted level. Funding will support activities such as the rural health research center grant program as well as general technical assistance and information dissemination related to these issues. This program will support the production of 35 reports in FY 2014 as well as policy brief, manuals and other resources focusing on identifying best practices in rural communities.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2011: 57 Target: 30 (Target Exceeded)	30	35	+5

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	12	12	12
Average Award	$750,000	$750,000	$750,000
Range of Awards	$150,000-$200,000	$150,000-$200,000	$150,000-$200,000

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$55,553,000	$55,893,000	$55,553,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 330A of the Public Health Service Act, as amended by Section 201, P.L. 107-251, as amended by Section 4, P.L. 110-355.

FY 2014 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants are a subcomponent of the Office of Rural Health Policy (ORHP). The purpose of the grants is to improve access to care, coordination of care, integration of services and to focus on quality improvement. The grants began as a demonstration program in 1993 and were formally authorized in 1996. There are multiple grant programs administered under this authority. All of the grants support collaborative models to deliver basic health care services to the 55 million Americans living in rural areas. The Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Five of these programs are part of HRSA's "Improve Rural Health" Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services. The program supports a wide range of services, including primary medical and dental care, mental health treatment, and health promotion and health education services.

These grants provide seed funding to rural organizations to address health disparities in their community. The programs are among the only non-categorical grants within HHS and that allows the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing need. Each of the programs focus on making the initial investment in a rural area with the expectation that the community will continue to provide the services at the conclusion of the grant funding. ORHP has begun to focus a great deal on sustainability to demonstrate the impact these programs make in rural communities.

Sustainability continues to be a priority for the community-based programs. Since the grants are short-term demonstration programs, it is important that the emphasis of sustainability is focused on from Year 1. ORHP works in conjunction with the technical assistance provider and the

grantee to help them develop and implement a sustainability plan. The primary areas that are emphasized include leadership, organizational capacity and collaboration. Collaboration has been shown to be one of the most effective ways for a program to continue to provide services once federal funding has ended. ORHP community-based programs are required to develop a consortium or network of organizations that play a key role in helping the grant to sustain. Often times, the consortium or network provide resources (monetary, staffing, etc.) that help the program to sustain once federal funds have ended. In addition, in the network programs, studies show that network member fees are the primary way the grant sustains. Other ways the grants sustain include in-kind resources and third-party reimbursement.
Each year, different programs within the Outreach authority closes out and, therefore, sustainability is assessed on those respective programs. As a result, it should be expected that there may be significant variations in the results from one year to the next. The most recent cohort of community-based grantees that completed federal funding is the Rural Healthcare Services Outreach grant program. The FY 2011 results showed that 98 percent of the programs will sustain either all or some of their programs, exceeding the target of 60 percent. The increase in sustainability can be attributed to increased technical assistance and emphasis around sustainability efforts.

In addition, ORHP has worked with The Lewin Group and The University of Washington Research Center to develop a generalizable formula which will allow rural communities to measure the economic impact their community investment makes. The tool will translate project specific impacts into community wide effects such as the number of jobs created, new spending and the impact of new and expanded services. The easy-to-use tool will assist rural programs in assessing their own performance and advocate for resources that contribute to the sustainability of programs and better health care for rural populations. A recent analysis of 59 Outreach grants, which completed the program in April, 2012, showed that for every HRSA dollar invested, approximately $1.50 was generated in the community.

Since 2004, ORHP has been working with the Center for Medicare and Medicaid Services (CMS) on two frontier demonstration: the Frontier Extended Stay Clinic (FESC) and the Frontier Community Health Integration Program (F-CHIP). The Medicare Prescription Drug Improvement and Modernization Act of 2003 authorized the three-year CMS FESC demonstration to test an enhanced clinic model in frontier areas to address the needs of seriously ill or injured patients who cannot be transferred to a hospital, or who need monitoring and observation for a limited period of time. The ORHP, through a cooperative agreement that began in 2004, has assisted five clinics with data collection and analysis, life safety and other facility improvements required by the CMS Conditions of Participation, essential equipment, enhanced staffing to support the FESC model, project evaluation, and related activities. ORHP has provided $1.5 million per year to assist the five clinics with preparing for and participating in the CMS demonstration that will end in March 2013. Section 123 of the Medicare Improvements to Patients and Provider's Act of 2008 (MIPPA) authorized the F-CHIP demonstration to develop and test new models for the delivery of health care services in frontier areas through improving access to, and better integration of, the delivery of health care to Medicare beneficiaries in four frontier-eligible states: Alaska, Montana, North Dakota and Wyoming. ORHP's appropriation in FY 2010 - FY 2011 included funding to support the HRSA

portion of the demonstration. In FYs 2012 - 2014, ORHP plans on continuing to support frontier and rural demonstrations through the Rural Health System Analysis and Technical Assistance (RHSATA) Cooperative Agreement, the purpose of which is to inform policy makers and rural health care providers about how changes in the health care delivery system may affect them, and to provide technical assistance to rural providers in identifying potential new approaches to health care delivery in their communities.

The Rural Health Care Services Outreach program legislation, as identified in the President's Budget through the Improving Rural Health Care Initiative, includes five key programs:

Outreach Services Grants, which focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion but can also support expansion of services such as primary care, mental and behavioral health as well as oral health care services. This program is part of the 'Providing direct health care services' and 'Building an evidence base for programs that improve rural community health.' The program will award approximately 80 continuation grants in FY 2014.

Rural Network Development Grants, which support building regional or local partnerships among local hospitals, physician groups, long-term care facilities and public health agencies to improve management of scarce health care resources. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health initiative." The program expects to award 50 new awards in FY 2014. In addition, the program supports the Rural Health Workforce Development Program which involves the development of rural health networks that focus on activities relating to the recruitment and retention of primary and allied health care providers in rural communities. The program plans to make 10 continuation awards in FY 2014.

Network Planning Grants Program, which began in 2004, provides funds to bring together key parts of a rural health care delivery system so they can work in concert to establish or improve local capacity and coordination of care. In addition, the program supports joint purchasing, bench-marking, and recruitment and retention efforts. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health" Initiative. The program will award as many as 15 new grants in FY 2014.

Small Health Care Provider Quality Improvement Grants, which began in 2006. These grants help to improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement initiatives using the Chronic Care Model and electronic patient registries. Specifically, the program focuses on addressing obesity, cardiovascular disease and diabetes given that rural residents tend to have higher rates of these diseases than their urban counterparts. This program is part of the 'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health Care Initiative." The program expects to make 60 continuation awards in FY 2014.

The Delta States Network Grant Program, which began in 2001 and provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. In addition, the program supports chronic disease management, oral health services, and recruitment and retention efforts. Unlike the programs mentioned above, this program is more geographically targeted given the health care disparities across this eight-state region. The program will award 12 continuation grants in FY 2014.

Programs within the Rural Health Care Services Outreach Program authority provided either indirect or direct services for 2,451,969 individuals in FY 2009, which exceeded the target of 930,000. This is a substantial improvement from FY 2008 in which 828,360 individuals were served. This measure was revised to examine the increase in the number of people receiving direct services through the Outreach grant. This measure focuses on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, and, thus, more accurate. In FY 2010, 383,776 individuals were directly served, exceeding its target of 380,000. In FY 2011, 615,849 individuals were directly served over the recent project period, exceeding its target of 385,000. The increase in the number is a result of the Quality Program which had a dramatic increase for two reasons: 1) increased focus on the chronic care model and how to utilize it effectively which has led to an increased in the number of patients; and 2) the second year of the program is focused on seeing patients and conducting quality improvement activities with them. The proportion of the target population served through Outreach Authority grants increased from a baseline of 4.3 percent in FY 2010 to 7 percent in FY 2011. This increase is due to the significant increase in the number of people receiving direct services through Outreach grants.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$55,905,000
FY 2011	$55,658,000
FY 2012	$55,553,000
FY 2013	$55,893,000
FY 2014	$55,553,000

Budget Request

The FY 2014 Budget Request is $55,553,000. The FY 2014 Request is equal to the FY 2012 Enacted level. This funding will continue to support the five key activities for Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs. In FY 2014, the program will support approximately 80 Outreach Services grants, 12 Delta grants, 50 Network Development grants, 10 Workforce grants, 60 Quality Improvement grants, and 15 Network Planning grants. ORHP expects that 400,000 people will receive direct services in FY 2014.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome)	FY 2011: 615,849 Target: 385,000 (Target Exceeded)	390,000	400,000	+10,000
29.IV.A.2: Increase the proportion of the target population served through Outreach Authority grants. (Outcome)	FY 2011: 7.0% (Target Not in Place)	5%	6%	+1% Point
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends. (Outcome)	FY 2011: 98% Target: 75% (Target Exceeded)	75%	60%	-15% Points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	247	227	227
Average Award	$175,000	$175,000	$175,000
Range of Awards	$75,000-$350,000	$75,000-$350,000	$75,000-$350,000

Rural Access to Emergency Devices

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,100,000	$2,511,000	---	-$1,100,000
FTE	2	2	---	-2

Authorizing Legislation - Public Health Service Act, Section 313, and Section 413, P.L. 106-505 of the Public Health Improvement Act

FY 2014 Authorization – Rural Access to Emergency Devices.....Expired
FY 2014 Authorization – Public Access Defibrillation Demonstration.....Expired

Allocation Method.....Competitive Grants

Program Description and Accomplishments

The Rural Access to Emergency Devices (RAED) Grant Program began in 2002 and provides funds to community partnerships which then purchase and distribute automatic external defibrillators (AEDs) to be placed in rural communities. The grants also provide training in the use of AEDs by emergency first responders. For the first four years of this program, large grants were given to States through a competitive process and the States then worked with their rural communities to identify where to place the AEDs and how to conduct training in their use. In FY 2006, the program was restructured and began making direct grants to community partnerships.

In FY 2004, additional funding was allocated for the Public Access to Defibrillation Demonstration Projects (PADDP). The purpose of this program is to support grants to political subdivision of states, federally-recognized Native American Tribes, or Tribal Organizations to develop and implement innovative, comprehensive, community-based public access defibrillation demonstration projects. The intent of the grant program is to support projects that will increase public access to emergency medical devices and services.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$2,521,000
FY 2011	$236,000
FY 2012	$1,100,000
FY 2013	$2,511,000
FY 2014	---

Budget Request

There is no FY 2014 Budget Request for Rural Access to Emergency Devices program and the Public Access Defibrillation Demonstration Project. The 2014 Request is $1,100,000 below the FY 2012 Enacted level. The discontinuation of funding for this program reflects a reprioritization of these funds to other activities within the Office of Rural Health Policy. Activities related to access to emergency medical devices and training in FY 2014 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. Rural residents could use both of these program authorities to support projects that include the purchase of AEDs and training in their use. In FY 2010, the total number of AEDs that were placed in rural communities was 3,928 which was an increase from 2,412 in FY 2009. Since the RAED Program was authorized in FY 2002, approximately $45,000,000 has been invested in rural communities to purchase, place and train providers to use AEDs.

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	8	8	---
Average Award	$100,000	$100,000	---
Range of Awards	$63,000-$100,000	$63,000-$100,000	---

Rural Hospital Flexibility Grants

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$41,040,000	$41,291,000	$26,200,000	-$14,840,000
FTE	1	1	1	---

Authorizing Legislation - Social Security Act, Section 1820(j), as amended by sec. 4201(a), P.L. 105-33 and Section 405 (f), P.L. 108-173, as amended by Section 121, P.L. 110-275.

FY 2014 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility activities are a component of the Office of Rural Health Policy (ORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are two grant programs administered under this authority. These grant programs are also a part the Improve Rural Health Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services.

The Medicare Rural Hospital Flexibility (Flex) Grant Program targets funding to over 1,300 critical access hospitals in 45 states. The re-authorization of the Flex Program in 2008 took into account that most conversions of hospitals to critical access hospital status have taken place. The new focus of the program includes providing support for CAHs for quality improvement, quality reporting, performance improvements and benchmarking. This program is part of the Improving the Quality of Health Care Services in Rural Areas' component of the Improve Rural Health Initiative. The Flex Program targets performance improvement and quality improvement activities within the CAH and the community through technical assistance and some direct support to hospitals.

In the past 12 years, the Flex Program and CAH designation has been instrumental in strengthening the infrastructure of these small rural hospitals, as evidenced in the trend of the operating margins improving from operating margins in negative double digits to close to zero. Economic viability is important in ensuring continued access to care, but quality improvement is now just as important. CAHs are not required to report to the Centers for Medicare and Medicaid Hospital Compare quality measures, but are encouraged to do so. The Flex Program includes a benchmarking and quality improvement project this grant cycle, expanding on the existing efforts to increase the percent of CAHs reporting on at least one measure to Hospital Compare, and making quality improvements around the measures reported.

The second program is the Flex Rural Veterans Health Access Program which began in 2010. This three-year program provides grants to three states with high percentage of veterans compared to the total population (Alaska, Montana and Virginia) and focuses on increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas. The program is targeting increased access for veterans through investments in telehealth and electronic health records for both access to needed services and continuity of care for veterans in rural communities. This program supported three continuation grants in FY 2011 and FY 2012.

Given the larger trends in health care, the Flex Program provides essential support to CAHs and help to prepare them to successfully navigate a future that will emphasize pay for performance and value based purchasing, while improving outcomes and managing growth in health care spending.

Programs	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Rural Hospital Flexibility (Flex) Grant Program	$25,200,000	$25,451,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$14,840,000	14,840,000	---
Flex Rural Veterans Health Access Program	$1,000,000	$1,000,000	$1,000,000

The Flex performance measures also reflect efforts to increase CAH participation in reporting at least one measure to CMS's Hospital Compare. The data posted on the Hospital Compare Website is a key part of the Department's ongoing efforts to increase transparency in the health care system by measuring all hospitals. The FY 2006 baseline for this measure is 63.14 percent of CAHs reporting at least one measure to Hospital Compare. Since FY 2006, there has been a steady progression each year of CAHs reporting at least one measure: 69 percent in FY 2007; 70 percent in FY 2008; 70.3 percent in FY 2009; and 72.6 percent for FY 2010.

Emergency medical services (EMS) are also an important part of the Flex Program and help to support quality and viability of rural communities across the continuum of care. The number of individuals trained in EMS leadership and/or trauma courses declined from 3,613 in FY 2008 to 3,002 in FY 2009. In FY 2010, 2,996 individuals were trained, not meeting its target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$40,915,000
FY 2011	$41,118,000
FY 2012	$41,040,000
FY 2013	$41,291,000
FY 2014	$26,200,000

Budget Request

The FY 2014 Budget Request is $26,200,000. The FY 2014 Request is $14,840,000 below the FY 2012 Enacted level. The reduction would result in discontinuation of new grants in FY 2014 for the Small Hospital Improvement Program (SHIP). Given the challenging economic times, there is a need to focus limited resources on where programs can have the most impact to meet hospital's needs and ensure that they maintain access to needed inpatient, outpatient and emergency care services in small rural communities. The FY 2014 request focuses on those communities served by Critical Access Hospitals, the smallest set of rural hospitals. Those hospitals previously supported by the SHIP can still qualify for support for quality improvements through the Affordable Care Act's Partnership for Patients, which includes a rural affinity group to work with small rural hospitals on patient safety and reduction of all-cause harm. Because 1,300 of the approximately 1,600 hospitals eligible for funding through the SHIP are CAHs and have access to the funding from the Flex Program, the budget request focuses on supporting CAHs by maintaining essential support for the Flex program and its focus on working with CAHs to improve quality. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare (FY 2014 target: 85 percent), engage in patient satisfaction surveys for quality and operational improvement (FY 2014 target: 60 percent), and to invest grant dollars in Emergency Medical Services (EMS) training and trauma system development (FY 2014 target: 2,995). The program will award 45 grants in FY 2014. Support for the Rural Veterans Health Access Program will allow for continued efforts to increase access for rural veterans to needed services. This program will support three grants in FY 2014.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	FY 2010: 72.6% Target: 72% (Target Exceeded)	76%	85%	+9%
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2010: 2,996 Target: 3,615 (Target Not Met)	3,615	2,995	-620
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	FY 2010: 38% (Baseline)	N/A	60%	N/A

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	49	48	48
Average Award	$490,000	$490,000	$490,000
Range of Awards	$256,000-$640,000	$256,000-$640,000	$256,000-$640,000

State Offices of Rural Health

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$10,036,000	$10,097,000	$10,036,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 338J of the Public Health Service Act as amended by Section 301, P.L. 105-392.

FY 2014 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The State Offices of Rural Health (SORH) Grant Program is a key component of the Office of Rural Health Policy (ORHP). The SORH Program was created in 1992 to support rural health care in each of the 50 states by providing grants to states to establish and maintain SORHs. The grantees collect and disseminate health-related information in rural areas. They also provide technical and other assistance to rural health providers, including small rural hospitals. SORHs also help communities recruit and retain health professionals. Each dollar of Federal support for the program is matched by three state dollars. The SORH Program is part of the Improve Rural Health Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services and falls under the Improve the Recruitment and Retention of Health Care Providers in Rural Areas component of the Initiative.

Two of the SORH measures reflect the technical assistance activities and focus on the number of technical assistance encounters provided directly to clients by SORHs as well as the number of clients (unduplicated) that receive technical assistance directly from SORHs. The number of technical assistance encounters provided directly to clients has increased from 62,296[1] in FY 2008 to 63,701[2] in FY 2009 to 78,075[3] in FY 2010 and to 84,140 in FY 2011. The number of clients receiving technical assistance directly has varied, from 27,161[4] in FY 2008, decreasing in FY 2009 to 26,552[5], another decline in FY 2010 to 22,187[6], with an increase to 25, 441 in FY 2011. Although there was a significant increase, the FY 2011 result did not meet the target. The third measure reflects the work facilitated by the SORHs through recruitment initiatives in the number of clinician placements. The FY 2008 baseline for this measure is 1,023 and the FY 2010 result is 1,544. The SORHs have been instrumental in helping rural constituents to meet the challenges through sharing information and providing technical assistance around the changing environment that rural health providers face, both with the passage of meaningful use requirements under the American Recovery and Reinvestment Act and the Affordable Care Act.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$10,005,000
FY 2011	$10,005,000
FY 2012	$10,036,000
FY 2013	$10,097,000
FY 2014	$10,036,000

Budget Request

FY 2014 Budget Request is $10,036,000. The FY 2014 Request is equal to the FY 2012 Enacted level. This funding will continue to support key activities for the State Offices of Rural Health Program and will support a grant award to each of the 50 states. It is part of HRSA's Improve Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain health care professionals. The SORH program anticipates that it will provide 67,601 technical assistance encounters directly to clients in FY 2014. The program also expects that 22,408 clients will receive technical assistance directly from SORHs. Additionally, the program hopes to facilitate 1,260 clinician placements in FY 2014.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2011: 86,140 Target: 65,614 (Target Exceeded)	66,269	67,601	+1,332
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2011: 25,541 Target: 30,521 (Target Not Met)	30,826	22,408	-8,418
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment	FY 2010: 1,544 Target: 1,033 (Target Exceeded)	1,053	1,260	+207

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
initiatives. (Outcome)				

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	50	50	50
Average Award	$178,000	$178,000	$178,000
Range of Awards	$160,000-$180,000	$160,000-$180,000	$160,000-$180,000

Radiation Exposure Screening and Education Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,935,000	$1,947,000	$1,935,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 417C of the Public Health Service Act, as amended by Section 4, P.L. 106-245, as further amended by Section 103 and Section 104, P.L. 109-482.

FY 2014 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP), which began in 2002, provides grants to States, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act.

The program measures the total number of individuals screened at RESEP centers each year and maintained the number of users over the past few years - FY 2009 (1,373), FY 2010 (1,371) and FY 2011 (1,366). These results are somewhat lower than the targets due to the rapidly aging former uranium mine worker population in which potential patients have passed away as well as the relocation of this population from the original mining sites. The program partners with the Department of Justice to collect data in support of this measure and has adopted steps to ensure that grantees comply with uniform screening guidelines. In addition, the program has undertaken new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

The program also measures the average cost of the program per individual screened and the results have been shown to be higher in FY 2009 ($1,249), FY 2010 ($1,251) and FY 2011 ($1,093) than the targets. The total number of individuals screened at RESEP centers each year greatly impacts the results for this measure. These results are somewhat higher than the targets due to the increasing cost of procedures and screenings at these RESEP centers.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$1,948,000
FY 2011	$1,939,000
FY 2012	$1,935,000
FY 2013	$1,947,000
FY 2014	$1,935,000

Budget Request

The FY 2014 Budget Request is $1,935,000. The FY 2014 Request is equal to the FY 2012 Enacted level. This funding will continue to support key activities for Radiation Exposure Screening and Education Program. The program will continue to support eight grantees in FY 2014, and the target for the number of individuals screened is 1,400.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
32.1: Percent of RECA successful claimants screened at RESEP centers.) [1] (Outcome)	FY 2008: 8.5% Target: N/A (3-year rolling baseline)	N/A	N/A	N/A
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. [1] (Outcome)	FY 2008: 70% Target: N/A (Baseline)	N/A	N/A	N/A
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2011: 1,366 Target: 1,400 (Target Not Met)	1,400	1,400	0
32.E: Average cost of the program per individual screened (Efficiency)	FY 2011: $1,093 Target: $923 (Target Not Met)	$1,397	$1,251	-$146

Grants Awards Table
Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	8	8	8
Average Award	$235,827	$235,827	$235,827
Range of Awards	$180,000-$279,000	$180,000-$279,000	$180,000-$279,000

Black Lung

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$7,140,000	$7,184,000	$7,140,000	---
FTE	---	---	---	---

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a), P.L. 91-173 as amended by Section 5(6), P.L. 92-303 amended by Section 9, P.L. 95-239, as further amended by CFR Part 55A.

FY 2014 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Black Lung Program was established in 1980 and provides funds through project grants to public and private entities, including faith-based and community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. Other patients include steel mill workers, agricultural workers, and others with occupationally-related respiratory and pulmonary disease. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increase along with the cost of those services.

In FY 2011, the program supported services to 12,840 miners, which exceeded the target of 12,288 miners. The program also provided 18,129 medical encounters in FY 2011, which was below its target of 25,403. The increased in miners served and the decrease in medical encounters may be partially explained by the increased program focus on benefits counseling activities, such as depositions, hearings, and Department of Labor (DOL) claim applications filed. The number of encounters per million dollars in Federal funding in FY 2011 was 10,374 which exceeded its target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$7,185,000
FY 2011	$7,153,000
FY 2012	$7,140,000
FY 2013	$7,184,000
FY 2014	$7,140,000

Budget Request

The FY 2014 Budget Request is $7,140,000. The FY 2014 Request is equal to the FY 2012 Enacted level. This funding will continue to support key activities for Black Lung Program. The program expects to fund 15 continuation awards in FY 2014 and meet the target of 12,840 miners served. In addition, the program expects to reach the target of 18,129 medical encounters in FY 2014.

Recent information from the Centers for Disease Control National Institute of Occupational Safety and Health (CDC/NIOSH) indicates that the prevalence of coal workers' pneumoconiosis (CWP), also known as black lung disease, is rising. In fact, a recent study of 2,000 coal miners from Utah to Pennsylvania showed five times as many miners have CWP than 10 years ago. Many miners are developing severe CWP before 50 years of age, and there is some evidence that this is being manifested as premature mortality. In addition, data from the U.S. Department of Labor show the number of federal black lung benefits claims has increased, suggesting that the disease is also leading to increased significant, long-term disability. ORHP plans to consult with providers, experts, and federal partners in FY 2013 to thoroughly reassess the priorities and scope of the program, while taking into account regulatory requirements. It will also provide an opportunity to ensure funding levels as well as program resources are most effectively coordinated with other Federal efforts to address growing target population needs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
33.1: Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program. [204] (Outcome)	FY 2008: 80% Target: N/A (Baseline)	N/A	85%	N/A

[204] The target for this long-term measure is 85% (FY 2014).

33.I.A.1: Number of miners served each year. (Output)	FY 2011: 12,840 Target: 12,288 (Target Exceeded)	12,836	12,840	+4
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2011: 18,129 Target: 25,403 (Target Not Met)	26,403	18,129	-9,274
33.E: Increase the number of medical encounters per $1 million in federal funding. (Efficiency)	FY 2011: 10,374 Target: 4,172 (Target Exceeded)	4,272	10,374	+6,002

Grants Awards Table
Size of Awards

(whole dollars)	**FY 2012 Enacted**	**FY 2013 Annualized CR**	**FY 2014 President's Budget**
Number of Awards	15	15	15
Average Award	$381,562	$381,562	$381,562
Range of Awards	$116,742-$697,740	$116,742-$697,740	$116,742-$697,740

Telehealth

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$11,502,000	$11,572,000	$11,502,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 330I of the Public Health Service Act; as amended by Public Law 107-251, as further amended by Public Law 108-163.

FY 2014 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) administers three grant programs that support telehealth technologies:

- Telehealth Network Grant Program (TNGP), which includes funding projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in rural, and frontier communities. Specifically, the networks can be used to: (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families. The primary objective of the TNGP is to help communities build the human, technical, and financial capacity to develop sustainable telehealth programs and networks. The Telehomecare grant program is a small cohort within the TNGP that focuses on demonstrating how telehealth networks improve healthcare through provision of clinical care and remote monitoring of patients in their place of residence using telehealth technologies;

- Telehealth Resource Center Grant Program (TRCGP), which provides technical assistance to communities wishing to establish or enhance telehealth services; and

- Licensure Portability Grant Program (LPGP), which provides support for State professional licensing boards to carry out programs to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

As of FY 2010[205], this cohort of TNGP grantees provided a total number of 147 clinical services, across 1,509 sites in underserved rural communities for a total of 1,656 sites and services. When added to the FY 2008 baseline of 1,295, TNGP grantees supported 2,951 sites

[205] The OAT next set of results for FY 2011 will be available in March 2013.

and services in these communities since FY 2005, exceeding the target for FY 2010. As a result, a gradual expansion of sites and/or services is evident across the three year project period (FY 2009-2012). In FY 2010, 321 communities had access to pediatric services and 320 communities had access to adult mental health services for which they otherwise would not have had access in the absence of the TNGP grants. Between FY 2009 and FY 2010, these results show a relative stability since new project period began in FY 2009.

In addition, the Program began in FY 2006 to collect data on a long-term measure to assess the program's impact on clinical outcomes in diabetic patients served by the grantees of the TNGP program, targeting control of hemoglobin A1c levels in patients. Since then, ideal glycemic control has been gradually achieved, while in FY 2009, 44 percent were able to achieve ideal glycemic control compared to a target of 14.5 percent. In FY 2010, 32 percent achieved ideal glycemic control, highlighting a continual upward trend.

The OAT Programs are an integral component of the Improve Rural Health Care Initiative to expand the use of telecommunications technologies that increase the access to and quality of health care provided to rural and underserved populations. The Telehealth Programs strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas. Under the current authorization of the TNGP, the authority allows HRSA to fund urban hub sites and rural spoke sites. In FY 2012, HRSA supported networks in rural underserved communities that are experiencing severe shortages of health care professionals.

In FY 2012, OAT awarded 23 grants that supported telehealth networks and telehomecare networks, 13 Telehealth Resource Grant Program grants were awarded, and two grants to improve licensure coordination among states.

Table 1. Actual Grant Dollars to be awarded for grants

Programs	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Telehealth Network Grant Program	$6,250,000	$6,250,000	$6,250,000
Licensure Portability Grant Program	$350,000	$350,000	$350,000
Telehealth Resource Center Grant Program	$4,150,000	$4,220,000	$4,150,000
Contracts	$427,000	$427,000	$427,000
Interagency Agreements	$325,000	$325,000	$325,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2010	$11,575,000
FY 2011	$11,524,000
FY 2012	$11,502,000
FY 2013	$11,572,000
FY 2014	$11,502,000

Budget Request

The FY 2014 Budget Request is $11,502,000. The FY 2014 Request is equal to the FY 2012 Enacted level. The funds will support: (1) TNGP grantees (23 grants); (2) TRCGP grantees (up to 13 grants); and (3) The Licensure Portability Grant Program (two grants), as well as associated technical assistance and evaluation activities. Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 30 percent in FY 2014 (for the FY 2012-2015 cohort). Additionally, OAT anticipates that 204 communities will have access to adult mental health services and 239 communities will have access to pediatric and adolescent mental health services by FY 2014.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Outcome)	FY 2010: 32% Target: 21% (Target Exceeded)	20%	30%	+9
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [206] (Outcome)	FY 2005: 100% (Baseline) Target: N/A (Target Not In Place)	N/A	N/A	N/A
34.III.D.2: Expand the number of telehealth services (e.g., dermatology,	FY 2010: 2,951 Target: 2,456 (Target Exceeded)	2,556	2,579	+23

[206] This is a long term measure with FY 2013 as a long-term target date.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
cardiology) and the number of sites where services are available as a result of the TNGP program. [207] (Outcome)				
34.III.D.1: Increase the number of communities that have access to pediatric and adolescent mental health services where access did not exist in the community prior to the TNGP grant. (Outcome)	FY 2010: 321 Target: 219 (Target Exceeded)	223	239	+16
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in the community prior to the TNGP grant. (Outcome)	FY 2010: 320 Target: 186 (Target Exceeded)	188	204	+16
34.E: Expand the number of services and/ or sites provide access to health care as a result of the TNGP program per Federal program dollars expended. [208] (Efficiency)	FY 2010: 255 per Million $ Target: 186 per Million $ (Target Exceeded)	202 per Million $	203 per Million $	+1

Grants Awards Table
Size of Awards

[207] Please note: Because this is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported Telehealth activities. The data are calculated as a cumulative number. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets for FY 2014 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[208] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years a new cohort of grantee commences with a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are being put in place but are not yet implemented.

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	40	40	38
Average Award	$262,195	$262,195	$262,195
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

Program Management

Tab

Other Programs

Program Management

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$159,894,000	$162,500,000	$161,794,000	+1,900,000
FTE	862	853	855	-7

Authorizing Legislation: Section 301 of the Public Health Service Act.

FY 2014 Authorization……...……Indefinite

Allocation Method……....Other

Program Description and Accomplishments

HRSA's Program Management activity operates programs budgeted in FY 2014 at more than $9 billion. HRSA's mission is to provide the National leadership, resources and services necessary to improve and expand access to quality healthcare for all Americans. To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. Program Management activity is the primary means of support for FTEs and overhead expenses such as rent, utilities and miscellaneous charges.

Program Management personnel plan, coordinate, and direct technical assistance and program guidance to clients of all of HRSA's authorized programs.

In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, which include:

National Practitioner Data Bank;
Health Education Assistance Loan Program; and
Vaccine Injury Compensation Program.

Significant progress has been made in a range of Program Management activities. The effort to continuously improve and secure the Information Technology infrastructure includes improving the perimeter protection through implementation of additional security tools that provide HRSA with a state of the art Intrusion Detection System, while simultaneously reducing physical servers as part of ongoing virtualization and consolidation initiative. The Agency has continued to mature the processes for the initiation, execution, management and oversight of IT Investments through the continued implementation of the HRSA Enterprise Architecture and Capital Planning and Investment Control (CPIC) processes and the more recent implementation of an Enterprise Performance Life Cycle (EPLC) Framework. Funding for Program

Management includes IT funding for the continued development, operations and maintenance of enterprise functionality of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that supports the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis. The HRSA Data Warehouse is the official repository for current HRSA data and promotes maximum operating efficiency through centralization, reconciliation, and standardization of data across HRSA's various transactional business systems. The Data Warehouse cleanses and standardizes data, applies established business rules to validate the data, and enriches and expands the data available from the sources. The Data Warehouse promotes openness and transparency of government by providing HRSA and the general public with a single source of HRSA programmatic information, related health resources, demographic, and statistical data for analyzing and reporting on HRSA activities with easily accessible, readily-available pre-designed tools, charts, maps, and reports.

Funding History

FY	**Amount**
FY 2010	$147,052,000
FY 2011	$161,815,000
FY 2012	$159,894,000
FY 2013	$162,500,000
FY 2014	$161,794,000

Budget Request

The FY 2014 Budget Request of $161,794,000 is an increase over the FY 2012 Enacted Level. The budget request supports increases for salaries, benefits and IT expenses. HRSA is committed to improving the quality of output at a lower cost and improving the speed of government operations. HRSA is working towards its goal to reduce the IT network infrastructure and data center footprint by twenty percent. In addition, HRSA is reducing travel costs and supporting telework participation by increasing the agency-wide utilization of web collaboration tools by twenty- five percent, which will lead to greater business productivity.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Request	FY 2014 Request +/- FY 2013 PB
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2012: Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff. (Target Met)	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	---
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate(Output)	FY 2012: 100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO). (Target Met)	All HRSA new systems will be assessed and authorized to operate prior to going into production. All existing systems that are due for reauthorization will be reassessed and reauthorized to operate.	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applies, security controls are implemented	---

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Request	FY 2014 Request +/- FY 2013 PB
			and working as intended, and risks are managed and mitigated in a timely manner.	
35.VII.B.3: Capital Planning and Investment Control (Output)	FY 2012: 1) 100% of major investments received an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers are in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met)	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	---

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Request	FY 2014 Request +/- FY 2013 PB
35.VII.A.3: Strengthen Program Integrity (PI) Activities	FY 2012: (1) Reached staffing of eleven PI analysts in the regions and three PI analysts at HQ to increase auditing/site visit capability. (2) HRSA PI Workgroup continued development of the online PI toolkit to provide standardized PI information and reference tools, including the implementation of phase 1. (Target Met)	Add 4 PI staff to result in one per region. Implement Phase I of the online PI toolkit, including HHS and HRSA-wide guidance, information and reference tools.	1) Reach staffing of 20 PI regional analysts 2) Complete the final phase (phase 3) of the online PI toolkit through the addition of additional sections of program-specific guidance, information, and reference tools.	---

Family Planning

Tab

Family Planning

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$293,870,000	$298,655,000	$327,402,000	33,532,000
FTE	33	33	33	--

Authorizing Legislation: Title X of the Public Health Service Act
FY 2013 Authorization…….Indefinite
Allocation Method ..... Competitive Grant, Contract, Direct

Program Description and Accomplishments
The Title X Family Planning Program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the Title X Program, which funds more than 4,000 sites designated as essential community providers under the ACA, is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to persons from low-income families.

The public health value of family planning services is well documented. Cited by the CDC in 1999 as one of the greatest public health achievements of the 20th century, family planning services have been used by millions of individuals in the United States and around the world. In this spirit, the Title X Family Planning Program is committed to the delivery of high-quality family planning and reproductive health services to all women and men who want them. Guided by nationally recognized standards of care, all Title X funded family planning centers provide contraceptive methods, education and counseling, as well as related preventive health services to their clients.

The Title X Program has greatly contributed to decreasing unintended pregnancy among women and families, as well as significantly reducing unintended pregnancy rates among teens and young adults. According to the most recent data (CY 2011), of the more than five million individuals served each year in Title X clinics, approximately 21 percent were under 20 years of age and more than 2.5 million (51 percent) were in their 20s (2011 Family Planning Annual Report (FPAR)). By providing comprehensive family planning and related reproductive and preventive health services (e.g., STD and HIV prevention, education and screening), unintended pregnancy, infertility and related morbidity have been reduced for these populations.

In order to ensure that the Title X family planning program is responsive to the ever-changing needs of clients, and is adhering to the letter and spirit of the statute, the program commissioned a two-year independent evaluation by the Institute of Medicine (IOM), completed in May 2009. Among the findings from the evaluation, it was noted that the Title X program is extremely resilient and valuable, especially in providing family planning services to its priority population – individuals from low-income families.

The Title X Program fulfills its mission through grants awarded to public and private nonprofit organizations to support the provision of family planning services, information, and education. According to 2011 FPAR data, services were provided through 91 family planning service grants that support a nationwide network of 4,382 community-based sites that provide clinical and educational services to more than 5,000,000 persons annually. Grantees include state and local health departments, hospitals, community health centers, Planned Parenthood centers, and other private nonprofit agencies. There is at least one Title X services grantee in every state and U.S. territory. Title X family planning program regulations require that projects provide a broad range of effective and acceptable family planning methods and related preventive health services.

A 2011Guttmacher Institute publication indicated that for more than half of clients seen in publicly-funded family planning clinics, such as Title X, clients reported that the site was their "usual" or only continuing source of health care and/or health education. Historically, approximately 90 percent of the clients served each year in Title X-funded sites have family incomes at or below 200 percent of the federal poverty level.

The Title X Family Planning Program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for all levels of family planning agency personnel through a national training program; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services. In addition, each year the program establishes a set of program-wide priorities that provide guidance to grantees in an effort to ensure high-quality, responsive and appropriate family planning service delivery. In the past several years, the priorities have focused on building the program's capacity to address needs of clients and sustainability of the family planning network. Program priorities have stressed the need to expand access to a broad range of effective and acceptable family planning methods, including Long-Acting Reversible Contraceptives (LARCs).

Broader access to highly effective but relatively expensive methods of contraception has been recognized as a key strategy to reducing unplanned pregnancies. At the same time, clinics have been expected to provide a broader array of primary care services. As a result, the ability of some providers to address the increasingly complex needs of clients served by Title X family planning centers has created added stress to the program. Since FY 2007, the program has focused on improving clinic efficiency in an effort to address the increasing cost of health care without sacrificing quality. Establishing clinic efficiency as a national training priority led to region-specific plans to address clinic efficiency through quality assurance/continuous quality improvement efforts and emphasis on implementing appropriate staffing patterns, purchasing strategies and other cost saving measures. These strategies and best practices were compiled in a national training compendium of clinic efficiency efforts with a focus on the best methods to address client needs and mitigating the effects of medical cost increases. In FY 2010, the program began assessing and evaluating these efforts and the impact on Title X family planning service delivery. The final analyses of the evaluations are in the process of being completed, but it appears that these targeted training strategies have contributed to some extent to a decrease in the cost per client via controlling cost and increasing clinic efficiency.

In 2011, the most recent year for which final data are available, the program accomplished the following: Served 5,021,711 clients, helping to avert an estimated 964,000 unintended

pregnancies, approximately 200,000 among teens. In addition, service sites provided more than 1.33 million Chlamydia tests for15–24 year old females, preventing an estimated 1,573 cases of STD-related infertility. Targets were exceeded for the number of screenings for Chlamydia infection in females ages 15–24. The number of unintended pregnancies averted fell short of the target by approximately 0.6% due to an overall decrease in the number of female clients receiving family planning and related preventive health services at Title X-funded service sites.

Cervical cancer screenings also declined. While at first glance this may seem problematic, it likely reflects adherence to new recommendations from nationally recognized organizations such as American Congress of Obstetricians and Gynecologists (ACOG), American College of Surgeons (ACS), and US Preventive Services Task Force (USPSTF). These revised standards of care recommend that screening be initiated later in life and, for most women, performed less frequently. Currently, these organizations recommend that cervical cancer screening begin at age 21, and between ages 21–65, be performed every three years (beginning at age 30, in place of traditional cytology, screening through HPV co-testing may be performed every five years). As providers move away from the long-standing recommendation of annual testing, fewer cervical cancer screenings will be performed in all settings, including Title X clinics. FPAR data support this trend, with the latest data indicating that the proportion of women screened for cervical cancer in Title X family planning centers decreased from 52 percent in 2005 to 31 percent in 2011.

Despite the continued rise in medical care costs, the family planning program has historically been able to maintain the average cost per Title X client at or below the medical care rate of inflation. In 2011, the program performed better than its projected target, and, in addition, the cost per client rose at a lower rate as compared with the Consumer Price Index (CPI) for medical care (3.36% versus 3.6%). Over the past 5 years (2007 to 2011), the program's cost per client has risen 3.45 percent on average – lower than the medical CPI of 3.64 percent. Although some increase in the cost per client is expected and anticipated, the slower average growth (versus the CPI) over the past years is influenced by many factors, including investments Title X grantees and services sites have made in technology and other infrastructure advancements, such as incorporating electronic health records and implementing strategies to improve clinic efficiency their ability to effectively leverage multiple sources of revenue.

Affordable Care Act

After full implementation of the ACA, the Title X family planning program will continue to support the family planning service delivery network across the nation, and provide outreach, education, and health services with the assistance of community health workers. The ACA recognizes the continued importance of these service sites and has designated them as "essential community providers." The Title X-funded infrastructure is expected to play a critical role in continuing to address health disparities, including reducing maternal and infant morbidity and mortality, as well as unplanned pregnancy and breast and cervical cancer, through the provision of primary, preventive reproductive health services to the program's target population – many of whom will continue to be in need of subsidized services because they are uninsured or require a level of privacy not guaranteed in other settings. Through the help of Title X funding, these clinics are able to serve as a point of access for low income individuals seeking primary, preventive reproductive health services. Title X funds will also assist clinics to provide services required by the ACA, to address new and ongoing health information technology (HIT) needs,

and to address issues related to the recruitment and retention of the clinical workforce, largely nurse practitioners, that serve as the backbone of the program.

Additionally, at the national, regional and local levels, the program will continue to collaborate with other public health programs, including HRSA's Maternal and Child Health Bureau, Bureau of Primary Health Care, and HIV/AIDS Bureau; CDC's Divisions of STD Prevention and Reproductive Health; and, OASH's Office on Women's Health, Office of Adolescent Health, and Office of Minority Health.

Funding History

FY	Amount
FY 2010	$316,832,000
FY 2011	$299,400,000
FY 2012	$293,870,000
FY 2013	$298,655,000
FY 2014	$327,402,000

Budget Request

The FY 2014 request is $327,402,000, an increase of $33,532,000 above the FY 2012 Enacted level. The budget request provides funding for family planning methods and related preventive health services, as well as related training, information, education, and research to improve family planning service delivery. Family planning service projects enable the program to achieve the overall goal of providing family planning and related preventive health services to individuals in the communities served by Title X family planning centers.

The FY 2014 request is expected to support family planning services for approximately 5,045,000 persons, with approximately 90 percent having family incomes at or below 200 percent of the Federal poverty level. These services include the provision of family planning methods, education, counseling, and related preventive health services. The performance of the program is reflected in the outcome measures developed during its performance assessment. These outcomes include preventing approximately 1,600 cases of infertility through Chlamydia screening of approximately 1,353,000 females ages 15-24, preventing 504 cases of invasive cervical cancer through cervical cancer screening, and preventing approximately 970,600 unintended pregnancies in FY 2014. Although the program will continue to emphasize efficiency, the targets for FY 2014 are ambitious and assume that other sources of revenue that contribute to the family planning program at the grantee level will remain at historical proportions of the total Title X revenue.

At least 90 percent of funding will continue to be used for clinical family planning services as defined under Section 1001 of the Title X statute. Funding will continue for Chlamydia screening in an effort to decrease infertility related to untreated Chlamydia infection, screening for undiagnosed cervical tissue abnormalities (ultimately reducing morbidity and related to the number of cases of invasive cervical cancer), and providing a broad range of contraceptive methods and related education and counseling, thereby reducing the number of unintended pregnancies.

In addition, the program aims to have new Title X Family Planning Services Guidelines during CY 2013. These new guidelines will reflect a foundation of empirical evidence and information supporting clinical practice that is expected to improve the provision of family planning and reproductive health services regardless of the service setting.

Outputs and Outcomes Tables

Long Term Objective: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
36.II.A.1: Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. *(Outcome)*	FY 2011: 5,021,711 Target: 5,049,000 (Target Not Met)	4,969,600	5,045,000	+75,400
36.II.A.2: Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	FY 2011: 89% Target: 90% (Target Not Met)	90%	90%	Maintain
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2011: 964,121 Target: 969,700 (Target Not Met)	949,300	970,600	+21,300

Long Term Objective: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15 – 24.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
36.II.B.1: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. *(Outcome)*	FY 2011: 1,333,149 Target: 1,324,000 (Target Exceeded)	1,296,300	1,353,000	+56,700

Long Term Objective: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. *(Outcome)*	FY 2010: 1,444,418 Target: 1,866,000 (Target Not Met)	1,654,900	1,528,000	-126,900
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. *(Outcome)*	FY 2011: 477 Target: 616 (Target Not Met)	546	504	-42

Efficiency Measure:

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2010: $256.20 Target: $269.55 (Target Exceeded)	$280.66	$283.85	+3.19

The Title X family planning program will use the FY 2014 request to enable family planning centers to provide quality preventive services to the low-income population served by Title X. The funding will provide a range of contraceptive options available in some centers, focused on increasing access to long-acting reversible contraceptives (LARCs), enhancing access to the HPV vaccine and other critical immunizations, expanding STI screening and HIV testing, and ensuring Title X clients receive a range of related preventive and reproductive health services at the more than 4,000 services sites across the nation.

The funding level reflects the importance of family planning, reproductive health, and related preventive health services and the cost-effectiveness of these primary care services. The program continues to face increases in the cost of medical care, the necessity of investing in health information technology, and the decreases in other sources of revenue that help to support family planning service delivery infrastructure. The funding level will enable Title X to have more ambitious targets related to the reduction of unintended pregnancy and the prevention of additional cases of STD-related infertility

In 2011, the program did not meet all expected performance targets; although in most cases by a minimal amount. Most notable was the number of unduplicated clients and the resulting number of unintended pregnancies averted. Many factors contributed to these results, including the increase in the number of states that imposed funding and policy restrictions on family planning,

reproductive, and related preventive health services. The failure to meet other 2011 targets could potentially indicate positive public health outcomes For example, decreases in cervical cancer screening may actually reflect greater adherence to changing recommendations related to the frequency of screening. The number of Chlamydia screenings for women ages 15–24 decreased from 2010, although the proportion of women screened increased from 57 to 58 percent between 2010 and 2011, and also exceeded the target. Considering that standards of care have changed over time, it is appropriate for the program to begin the process of reassessing performance measures and modify them to better reflect current clinical guidelines and overall preventive health practices that are indicative of high quality. Furthermore, decreases in cervical cancer screening may also reflect an increase in quality. USPSTF, ACOG and ACS generally recommend a longer interval between preventive screenings (i.e., cervical cytology (Pap tests)) than when the measure was adopted As a result; screening is expected to continue to fall, as more providers and clients follow the new standards of care.

The 2014 request reflects past trends, anticipated changes, and the implementation of improved strategies for delivering family planning, reproductive, and related preventive health care services. Though some provisions of the ACA have, or will already have been implemented prior to FY 2014, it is too early to predict specifically how changes in insurance coverage and access to health care services will affect the Title X family planning network, including performance measures and targets. It is anticipated that the provision of many aspects of family planning, reproductive, and related preventive health services will increase (e.g., women's preventive coverage, no co-pay for contraception, etc); however, the degree and magnitude of these impacts is difficult to forecast.

Overall, the FY 2014 request for the family planning program will enable critical support to health IT, staff, equipment, contraceptive supplies, immunizations, and other clinical services. In addition, the program will be able to monitor the impact of implementation of the ACA on the Title X system through data collected by all Title X family planning providers via the FPAR, and will modify data collection strategies as needed to best capture the most accurate and relevant information. OPA anticipates that the ACA and its provisions to expand coverage of women's preventive health services will enable more women to take advantage of the existing Title X network with its long history of providing confidential, high-quality family services.

Grant Awards Tables

Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	98	100	100
Average Award	$2,670,000	$2,643,000	$2,946,000
Range of Awards	$166,700 - $20,800,000	$168,300 - $21,050,000	$185,700 - $23,169,000

Supplementary Tables

TAB

Budget Authority by Object Class

DISCRETIONARY TOTAL

(in thousands)

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/Decrease
Full-time permanent (11.1)	125,292	123,641	-1,652
Other than full-time permanent (11.3)	5,329	5,312	-17
Other personnel compensation (11.5)	2,812	2,775	-37
Military personnel (11.7)	13,588	13,971	+ 383
Special personnel services payments (11.8)	589	591	+ 3
Subtotal personnel compensation	**147,610**	**146,290**	**-1,320**
Civilian benefits (12.1)	37,135	36,705	-431
Military benefits (12.2)	7,668	7,883	+ 215
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**192,413**	**190,878**	**-1,536**
Travel and transportation of persons (21.0)	2,541	2,477	-64
Transportation of things (22.0)	215	215	-
Rental payments to GSA (23.1)	17,264	16,889	-375
Rental payments to Others (23.2)	1,404	1,404	-
Communication, utilities, and misc. charges (23.3)	1,556	1,552	-4
Printing and reproduction (24.0)	288	286	-1
Other Contractual Services: 25.0	168	168	-
Advisory and assistance services (25.1)	13,069	11,497	-1,572
Other services (25.2)	135,604	133,665	-1,940
Purchase of goods and services from government accounts (25.3)	175,846	173,919	-1,926
Operation and maintenance of facilities (25.4)	1,269	1,269	-
Research and Development Contracts (25.5)	93	93	-
Medical care (25.6)	2,831	2,831	-
Operation and maintenance of equipment (25.7)	12,586	12,514	-72
Subsistence and support of persons (25.8)	42	42	-
Discounts and Interest (25.9)	13	13	-
Supplies and materials (26.0)	1,620	1,616	-4
Subtotal Other Contractual Services	**343,142**	**337,628**	**-5,513**
Equipment (31.0)	6,047	6,039	-9
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	5,572,738	5,368,899	-203,840
Insurance Claims and Indemnities (42.0)	68,142	88,772	+ 20,630
Total Non-Pay Costs	**6,013,338**	**5,824,161**	**-189,176**
Total Budget Authority by Object Class	**6,205,751**	**6,015,039**	**-190,712**

HEALTH CENTERS

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	12,862	12,827	-35
Other than full-time permanent (11.3)	632	640	+ 8
Other personnel compensation (11.5)	205	207	+ 2
Military personnel (11.7)	1,909	1,963	+ 55
Special personnel services payments (11.8)	23	23	-
Subtotal personnel compensation	**15,630**	**15,660**	**30**
Civilian benefits (12.1)	3,861	3,852	-9
Military benefits (12.2)	1,157	1,190	+ 33
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**20,648**	**20,702**	**54**
Travel and transportation of persons (21.0)	1,111	1,111	-
Transportation of things (22.0)	10	10	-
Rental payments to GSA (23.1)	194	194	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	527	527	-
Printing and reproduction (24.0)	3	3	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	33,964	33,177	-787
Purchase of goods and services from government accounts (25.3)	39,895	39,901	+ 7
Operation and maintenance of facilities (25.4)	65	65	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	4,796	4,796	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	103	103	-
Subtotal Other Contractual Services	**78,824**	**78,043**	**-780**
Equipment (31.0)	1,727	1,727	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,395,746	1,375,842	-19,904
Insurance Claims and Indemnities (42.0)	68,142	88,772	+ 20,630
Total Non-Pay Costs	**1,546,284**	**1,546,230**	**-54**
Total Budget Authority by Object Class	**1,566,932**	**1,566,932**	**-**

HEALTH WORKFORCE

Object Class	FY 2012 Enacted	FY 2014 Request	Increase/ Decrease
Full-time permanent (11.1)	7,324	6,724	-600
Other than full-time permanent (11.3)	488	479	-9
Other personnel compensation (11.5)	132	124	-7
Military personnel (11.7)	863	882	+ 19
Special personnel services payments (11.8)	157	159	-
Subtotal personnel compensation	**8,964**	**8,368**	**-596**
Civilian benefits (12.1)	2,282	2,095	-187
Military benefits (12.2)	389	396	+ 7
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**11,635**	**10,859**	**-776**
Travel and transportation of persons (21.0)	166	142	-24
Transportation of things (22.0)	2	2	-
Rental payments to GSA (23.1)	312	312	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	8	8	-
Printing and reproduction (24.0)	79	78	-1
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	1	-	-1
Other services (25.2)	12,650	11,806	-844
Purchase of goods and services from government accounts (25.3)	24,134	22,805	-1,329
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	1,689	1,620	-69
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	3	3	-
Supplies and materials (26.0)	54	54	-
Subtotal Other Contractual Services	**38,532**	**36,289**	**-2,243**
Equipment (31.0)	183	175	-8
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	674,767	492,939	-181,828
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**714,049**	**529,945**	**-184,104**
Total Budget Authority by Object Class	**725,684**	**540,804**	**-184,880**

MATERNAL AND CHILD HEALTH

Object Class	FY 2012 Enacted	FY 2014 Request	Increase/ Decrease
Full-time permanent (11.1)	5,475	4,624	-851
Other than full-time permanent (11.3)	6	5	-2
Other personnel compensation (11.5)	87	52	-36
Military personnel (11.7)	194	199	+ 6
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**5,762**	**4,879**	**-883**
Civilian benefits (12.1)	1,640	1,446	-193
Military benefits (12.2)	93	96	+ 3
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**7,495**	**6,421**	**-1,074**
Travel and transportation of persons (21.0)	294	258	-36
Transportation of things (22.0)	74	74	-
Rental payments to GSA (23.1)	226	151	-75
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	15	10	-4
Printing and reproduction (24.0)	5	5	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	10,122	8,838	-1,284
Other services (25.2)	5,321	5,101	-220
Purchase of goods and services from government accounts (25.3)	15,267	14,233	-1,035
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	8	8	-
Operation and maintenance of equipment (25.7)	1,104	1,102	-2
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	3	3	-
Supplies and materials (26.0)	5	4	-1
Subtotal Other Contractual Services	**31,831**	**29,289**	**-2,542**
Equipment (31.0)	508	508	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	812,908	788,146	-24,763
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**845,860**	**818,440**	**-27,420**
Total Budget Authority by Object Class	**853,355**	**824,861**	**-28,494**

HIV/AIDS

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	13,833	14,006	+ 173
Other than full-time permanent (11.3)	199	202	+ 2
Other personnel compensation (11.5)	245	248	+ 3
Military personnel (11.7)	810	833	+ 23
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**15,087**	**15,289**	**202**
Civilian benefits (12.1)	3,918	3,967	+ 49
Military benefits (12.2)	516	531	+ 15
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**19,522**	**19,788**	**+ 266**
Travel and transportation of persons (21.0)	172	172	-
Transportation of things (22.0)	14	14	-
Rental payments to GSA (23.1)	355	355	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-
Printing and reproduction (24.0)	9	9	-
Other Contractual Services: 25.0	167	167	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	20,841	20,841	-
Purchase of goods and services from government accounts (25.3)	65,169	65,169	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	4,480	4,480	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	75	75	-
Subtotal Other Contractual Services	**90,732**	**90,732**	**-**
Equipment (31.0)	880	880	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,255,495	2,275,229	+ 19,734
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**2,347,656**	**2,367,390**	**+ 19,734**
Total Budget Authority by Object Class	**2,367,178**	**2,387,178**	**+ 20,000**

HEALTHCARE SYSTEMS

Object Class	FY 2012 Enacted	FY 2014 Enacted	Increase/ Decrease
Full-time permanent (11.1)	5,031	4,775	-256
Other than full-time permanent (11.3)	241	225	-17
Other personnel compensation (11.5)	423	426	+ 3
Military personnel (11.7)	1,044	1,074	+ 30
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**6,739**	**6,499**	**(240)**
Civilian benefits (12.1)	1,520	1,446	-74
Military benefits (12.2)	396	408	+ 11
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**8,656**	**8,352**	**-304**
Travel and transportation of persons (21.0)	242	237	-5
Transportation of things (22.0)	66	66	-0
Rental payments to GSA (23.1)	300	-	-300
Rental payments to Others (23.2)	1,366	1,366	-
Communication, utilities, and misc. charges (23.3)	137	137	-
Printing and reproduction (24.0)	80	80	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	447	161	-287
Other services (25.2)	47,902	47,843	-60
Purchase of goods and services from government accounts (25.3)	3,000	2,068	-932
Operation and maintenance of facilities (25.4)	179	179	-
Research and Development Contracts (25.5)	93	93	-
Medical care (25.6)	2,823	2,823	-
Operation and maintenance of equipment (25.7)	182	182	-
Subsistence and support of persons (25.8)	42	42	-
Discounts and Interest (25.9)	7	7	-
Supplies and materials (26.0)	804	802	-2
Subtotal Other Contractual Services	**55,478**	**54,198**	**-1,280**
Equipment (31.0)	344	344	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	33,996	19,055	-14,941
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**92,010**	**75,484**	**-16,526**
Total Budget Authority by Object Class	**100,666**	**83,836**	**-16,830**

RURAL HEALTH

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	907	707	-200
Other than full-time permanent (11.3)	45	39	-5
Other personnel compensation (11.5)	10	6	-4
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	
Subtotal personnel compensation	**961**	**752**	**-209**
Civilian benefits (12.1)	272	221	-51
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**1,233**	**973**	**-260**
Travel and transportation of persons (21.0)	216	216	-
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	-	-	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	9,101	9,071	-30
Purchase of goods and services from government accounts (25.3)	2,868	2,782	-86
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	63	63	-1
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	21	20	-1
Subtotal Other Contractual Services	**12,053**	**11,935**	**-117**
Equipment (31.0)	30	30	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	124,640	109,077	-15,563
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**136,939**	**121,259**	**-15,680**
Total Budget Authority by Object Class	**138,172**	**122,232**	**-15,940**

FAMILY PLANNING

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	4,305	4,358	+ 54
Other than full-time permanent (11.3)	202	205	+ 3
Other personnel compensation (11.5)	21	21	-
Military personnel (11.7)	833	857	+ 24
Special personnel services payments (11.8)	37	38	-
Subtotal personnel compenstion	**5,398**	**5,479**	**81**
Civilian benefits (12.1)	1,293	1,309	+ 16
Military benefits (12.2)	326	335	+ 9
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**7,017**	**7,123**	**106**
Travel and transportation of persons (21.0)	187	187	-
Transportation of things (22.0)	1	1	-
Rental payments to GSA (23.1)	549	549	-
Rental payments to Others (23.2)	38	38	-
Communication, utilities, and misc. charges (23.3)	26	26	-
Printing and reproduction (24.0)	1	1	-
Other Contractual Services: 25.0	1	1	-
Advisory and assistance services (25.1)	2,489	2,489	-
Other services (25.2)	116	116	-
Purchase of goods and services from government accounts (25.3)	8,622	8,622	-
Operation and maintenance of facilities (25.4)	36	36	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	1	1	-
Operation and maintenance of equipment (25.7)	1	1	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	19	19	-
Subtotal Other Contractual Services	**11,283**	**11,283**	**-**
Equipment (31.0)	24	24	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	274,745	308,170	+ 33,425
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**286,853**	**320,279**	**33,425**
Total Budget Authority by Object Class	**293,870**	**327,402**	**33,532**

PROGRAM MANAGEMENT

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	75,556	75,620	+ 64
Other than full-time permanent (11.3)	3,515	3,518	+ 3
Other personnel compensation (11.5)	1,690	1,692	+ 1
Military personnel (11.7)	7,935	8,162	+ 227
Special personnel services payments (11.8)	371	371	-
Subtotal personnel compensation	**89,068**	**89,363**	**295**
Civilian benefits (12.1)	22,350	22,369	+ 19
Military benefits (12.2)	4,790	4,927	+ 137
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**116,208**	**116,659**	**451**
Travel and transportation of persons (21.0)	152	152	-
Transportation of things (22.0)	49	49	-
Rental payments to GSA (23.1)	15,329	15,329	-
Rental payments to Others (23.2)	0	0	-
Communication, utilities, and misc. charges (23.3)	844	844	-
Printing and reproduction (24.0)	111	111	-
Other Contractual Services: 25.0	0	0	-
Advisory and assistance services (25.1)	10	10	-
Other services (25.2)	5,709	5,709	-
Purchase of goods and services from government accounts (25.3)	16,891	18,340	+1,449
Operation and maintenance of facilities (25.4)	989	989	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	0	0	-
Operation and maintenance of equipment (25.7)	271	271	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	539	539	-
Subtotal Other Contractual Services	**24,410**	**25,859**	**+1,449**
Equipment (31.0)	2,351	2,351	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	441	441	-
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**43,686**	**45,135**	**+ 1,449**
Total Budget Authority by Object Class	**159,894**	**161,794**	**+ 1,900**

MANDATORY TOTAL

(Obligations in thousands)

Object Class	FY 2012 Actual	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	26,493	27,726	+ 1,232
Other than full-time permanent (11.3)	956	989	+ 34
Other personnel compensation (11.5)	362	402	+40
Military personnel (11.7)	6,630	6,819	+ 190
Special personnel services payments (11.8)	88	89	+ 1
Subtotal personnel compensation	**34,528**	**36,025**	**+ 1,497**
Civilian benefits (12.1)	8,036	8,351	+ 315
Military benefits (12.2)	3,568	3,670	+ 102
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**46,132**	**48,046**	**+ 1,914**
Travel and transportation of persons (21.0)	518	559	+ 41
Transportation of things (22.0)	150	150	-
Rental payments to GSA (23.1)	5,464	5,839	+375
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	258	258	-
Printing and reproduction (24.0)	15	15	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,043	16,614	+ 1,571
Other services (25.2)	46,107	36,136	-9,971
Purchase of goods and services from government accounts (25.3)	28,379	28,948	+569
Operation and maintenance of facilities (25.4)	251	121	-129
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	50	52	+ 2
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	70	73	+ 3
Subtotal Other Contractual Services	**89,900**	**81,945**	**- 7,955**
Equipment (31.0)	1	1	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,488,690	1,957,586	-531,104
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**2,584,996**	**2,046,354**	**-538,642**
Total Budget Authority by Object Class	**2,631,128**	**2,094,400**	**-536,728**

COMMUNITY HEALTH CENTER FUND (ACA)

Object Class	FY 2012 Actual	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	4,561	4,618	+ 57
Other than full-time permanent (11.3)	133	134	+ 1
Other personnel compensation (11.5)	48	48	-
Military personnel (11.7)	834	858	+ 24
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**5,575**	**5,658**	**+ 83**
Civilian benefits (12.1)	1,339	1,356	+ 17
Military benefits (12.2)	550	566	+ 16
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**7,464**	**7,580**	**+ 116**
Travel and transportation of persons (21.0)	-	-	-
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	296	296	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	31	31	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	18,771	18,771	-
Purchase of goods and services from government accounts (25.3)	- 6,999	- 6,999	- -
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	-	-	-
Subtotal Other Contractual Services	**25,770**	**25,770**	**-**
Equipment (31.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,137,296	1,212,324	+ 75,028
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**1,163,392**	**1,238,420**	**+ 75,028**
Total Budget Authority by Object Class	**1,170,856**	**1,246,000**	**+ 75,144**

PRIMARY CARE ACCESS (ACA)

Object Class	FY 2012 Actual	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	19,950	19,635	-315
Other than full-time permanent (11.3)	814	824	+ 10
Other personnel compensation (11.5)	259	258	-1
Military personnel (11.7)	5,308	5,460	+ 152
Special personnel services payments (11.8)	88	89	+ 1
Subtotal personnel compensation	**26,420**	**26,267**	**-153**
Civilian benefits (12.1)	6,098	6,006	-92
Military benefits (12.2)	2,603	2,678	+ 75
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**35,121**	**34,951**	**-170**
Travel and transportation of persons (21.0)	415	415	-
Transportation of things (22.0)	131	131	-
Rental payments to GSA (23.1)	5,169	5,169	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	216	212	-4
Printing and reproduction (24.0)	14	14	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	25,860	16,100	-9,760
Purchase of goods and services from government accounts (25.3)	- 18,619	- 17,869	- -750
Operation and maintenance of facilities (25.4)	129	-	-129
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	44	44	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	53	53	-
Subtotal Other Contractual Services	**44,705**	**34,066**	**-10,640**
Equipment (31.0)	1	1	-0
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	993,852	310,043	-683,809
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**1,044,502**	**350,049**	**-694,453**
Total Budget Authority by Object Class	**1,079,623**	**385,000**	**-694,623**

MATERNAL INFANT AND EARLY CHILDHOOD VISITING PROGRAM (ACA)

Object Class	FY 2012 Actual	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	1,982	2,235	+ 252
Other than full-time permanent (11.3)	9	9	+ 0
Other personnel compensation (11.5)	55	55	+ 1
Military personnel (11.7)	488	502	+ 14
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**2,534**	**2,801**	**+ 267**
Civilian benefits (12.1)	598	682	+ 83
Military benefits (12.2)	415	427	+ 12
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**3,547**	**3,909**	**+ 362**
Travel and transportation of persons (21.0)	103	103	-
Transportation of things (22.0)	20	20	-
Rental payments to GSA (23.1)	-	-	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	11	11	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,043	15,043	-
Other services (25.2)	933	933	-
Purchase of goods and services from government accounts (25.3)	- 2,337	- 2,337	- -
Operation and maintenance of facilities (25.4)	121	121	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	6	6	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	17	17	-
Subtotal Other Contractual Services	**18,458**	**18,458**	**-**
Equipment (31.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	321,510	383,498	+ 61,989
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**340,102**	**402,091**	**+ 61,989**
Total Budget Authority by Object Class	**343,649**	**406,000**	**+ 62,351**

PUBLIC HEALTH PREVENTION FUNDING

Object Class	FY 2012 Actual	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	-	1,238	+ 1,238
Other than full-time permanent (11.3)	-	22	+ 22
Other personnel compensation (11.5)	-	40	+ 40
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**-**	**1,299**	**+ 1,299**
Civilian benefits (12.1)	-	307	+ 307
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**-**	**1,607**	**+ 1,607**
Travel and transportation of persons (21.0)	-	41	+ 41
Transportation of things (22.0)	-		
Rental payments to GSA (23.1)	-	375	+ 375
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	-	4	+ 4
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	1,571	+ 1,571
Other services (25.2)	544	333	-211
Purchase of goods and services from government accounts (25.3)	- 424	- 1,743	- + 1,320
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	2	+ 2
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	-	3	+ 3
Subtotal Other Contractual Services	**967**	**3,652**	**+ 2,684**
Equipment (31.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	36,033	51,721	+ 15,688
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**37,000**	**55,793**	**+ 18,793**
Total Budget Authority by Object Class	**37,000**	**57,400**	**+ 20,400**

Salaries and Expenses

Discretionary

(in thousands)

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	125,292	123,641	-1,652
Other than full-time permanent (11.3)	5,329	5,312	-17
Other personnel compensation (11.5)	2,812	2,775	-37
Military personnel (11.7)	13,588	13,971	+ 383
Special personnel services payments (11.8)	589	591	+ 3
Subtotal personnel compensation	**147,610**	**146,290**	**-1,320**
Civilian benefits (12.1)	37,135	36,705	-431
Military benefits (12.2)	7,668	7,883	+ 215
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**192,413**	**190,878**	**-1,536**
Travel and transportation of persons (21.0)	2,541	2,477	-64
Transportation of things (22.0)	215	215	
Rental payments to Others (23.2)	1,404	1,404	-
Communication, utilities, and misc. charges (23.3)	1,556	1,552	-4
Printing and reproduction (24.0)	288	286	-1
Other Contractual Services: 25.0	168	168	-
Advisory and assistance services (25.1)	13,069	11,497	-1,572
Other services (25.2)	135,604	133,665	-1,940
Purchase of goods and services from government accounts (25.3)	57,082	51,087	-5,995
Medical care (25.6)	2,831	2,831	-
Operation and maintenance of equipment (25.7)	12,586	12,514	-72
Subsistence and support of persons (25.8)	42	42	-
Discounts and Interest (25.9)	13	13	-
Supplies and materials (26.0)	1,620	1,616	-4
Subtotal Other Contractual Services	**223,016**	**213,433**	**-9,583**
Total Non-Pay Costs	**229,020**	**219,368**	**-9,652**
Total Budget Authority by Object Class	**421,434**	**410,246**	**-11,188**

Salaries and Expenses

Mandatory

(in thousands)

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase/ Decrease
Full-time permanent (11.1)	26,493	27,726	-1,232
Other than full-time permanent (11.3)	956	989	-34
Other personnel compensation (11.5)	362	402	-40
Military personnel (11.7)	6,630	6,819	-190
Special personnel services payments (11.8)	88	89	-1
Subtotal personnel compensation	**34,528**	**36,025**	**-1,497**
Civilian benefits (12.1)	8,036	8,351	-315
Military benefits (12.2)	3,568	3,670	-102
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**46,132**	**48,046**	**-1,914**
Travel and transportation of persons (21.0)	518	559	-41
Transportation of things (22.0)	150	150	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	258	258	-
Printing and reproduction (24.0)	15	15	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,043	16,614	-1,571
Other services (25.2)	46,107	36,136	+ 9,971
Purchase of goods and services from government accounts (25.3)	18,684	19,253	-569
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	50	52	-2
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	70	73	-3
Subtotal Other Contractual Services	**79,955**	**72,129**	**+ 7,826**
Total Non-Pay Costs	**80,896**	**73,111**	**+ 7,785**
Total Budget Authority by Object Class	**127,028**	**121,157**	**+ 5,871**

FY 2014 Detail of Full Time Equivalents

Programs	2012 Actuals Civilian	2012 Actuals Military	2012 Actuals Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	147	20	167	147	20	167	147	20	167
Free Clinics Medical Malpractice	2	-	2	2	-	2	2	-	2
Community Health Center Fund (ACA)	37	10	47	37	10	47	37	10	47
HC- Facilities Construction/NHSC (ACA)	15	4	19	15	4	19	15	4	19
School-based Health Centers- Facilities (ACA)	5	-	5	5	-	5	5	-	5
Total:	**206**	**34**	**240**	**206**	**34**	**240**	**206**	**34**	**240**
Health Workforce:									
Bureau of Clinician Recruitment & Service									
Direct:									
National Health Service Corps (ACA)	201	47	248	201	47	248	201	47	248
Total:	**201**	**47**	**248**	**201**	**47**	**248**	**201**	**47**	**248**
Nurse Loan Repayment & Scholarships	24	5	29	24	5	29	24	5	29
Bureau of Health Professions									
Direct:									
Health Care Workforce Assessment	5	1	6	5	1	6	5	1	6
Scholarships for Disadvanted Students	4	-	4	4	-	4	4	-	4
Centers for Excellence	2	-	2	2	-	2	2	-	2
Health Careers Opportunity	1	-	1	1	-	1		-	-
Training in Primary Care Medicine/ Dentistry	5	-	5	5	-	5	5	-	5
Children's Hospitals Medical Education	21	2	23	21	2	23	16	2	18
Nurse, Education, Practice	4	-	4	4	-	4	4	-	4
Advanced Education Nursing Program	4	-	4	4	-	4	4	-	4
Geriatrics Program	3	1	4	3	1	4	3	1	4
GME Payments for Teaching Health Centers (ACA)	3	1	4	3	1	4	3	1	4

Programs	2012 Actuals Civilian	2012 Actuals Military	2012 Actuals Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
State Grants for Personal Home Health Aids (ACA).....	1	-	1	2	-	2	2	-	2
Public Health/Preventive Medicine.....	1	-	1	1	-	1	1	-	1
Nurse Workforce Diversity.....	1	-	1	1	-	1	1	-	1
Nurse Faculty Loan.....	1	-	1	1	-	1	1	-	1
Area Health Education Centers.....	2	-	2	2	-	2	-	-	-
Oral Health Training.....	2	-	2	2	-	2	2	-	2
Public Health Workforce Development.....	2	-	2	2	-	2	2	-	2
Mental and Behavioral Health.....	2	-	2	2	-	2	2	-	2
Comprehensive Geriatric Education.....	1	-	1	1	-	1	1	-	1
Heal…….....	13	-	13	13	-	13		-	-
Reimbursable:									
National Practitioner Data Bank.....	39	1	40	45	1	46	45	1	46
Healthcare Integrity & Protection Data Bank…….....	5	-	5		-	-		-	-
Total:.....	**122**	**6**	**128**	**124**	**6**	**130**	**103**	**6**	**109**
Maternal and Child Health Bureau:									
Direct:									
Autism and Other Developmental Disorders.....	5	1	6	5	1	6	5	1	6
Heritable Disorder Newborn Screening….....	4	-	4	4	-	4	4	-	4
Universal Newborn Screening.....	5	-	5	5	-	5	5	-	5
Block Grant	28	1	29	28	1	29	28	1	29
Healthy Start	5	-	5	5	-	5	5	-	5
Family to Family Health Info Centers (ACA)……....	1	-	1	1	-	1	-	-	-
Maternal, Infant & Early Childhood Visitation (ACA).....	19	4	23	21	4	25	21	4	25
Emergency Medical Services for Children.....	3	-	3	3	-	3	3	-	3
Sickle Cell Program.....	2	-	2	2	-	2	2	-	2
Total:.....	**72**	**6**	**78**	**74**	**6**	**80**	**73**	**6**	**79**

Programs	2012 Actuals Civilian	2012 Actuals Military	2012 Actuals Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	35	1	36	35	1	36	35	1	36
Ryan White Part B	56	-	56	56	-	56	56	-	56
Ryan White Part C	27	7	34	27	7	34	27	7	34
Ryan White Part D	10	1	11	10	1	11	10	1	11
Ryan White Part F	3	-	3	3	-	3	3	-	3
Ryan White Part F Dental	1	-	1	1	-	1	1	-	1
Reimbursable:									
OGAC Global AIDS	12	4	16	17	4	21	17	4	21
Total:	**144**	**13**	**157**	**149**	**13**	**162**	**149**	**13**	**162**
Healthcare Systems Bureau:									
Direct:									
C.W.Bill Young Cell Transplantation Program	7	-	7	7	-	7	7	-	7
Cord Blood Stem Cell Registry	3	1	4	3	1	4	3	1	4
Poison Control Centers	4	-	4	4	-	4	4	-	4
Covered Countermeasures Compensation	4	3	7	4	3	7	4	3	7
340B Drug Prcing Program/Office of Pharmacy Affairs	2	1	3	2	1	3	2	1	3
Hansen's Disease Center	53	6	59	53	6	59	53	6	59
Reimbursable:									
Hansen's Disease Center	3	-	3	3	-	3	3	-	3
Vaccine	19	3	22	19	3	22	19	3	22
DHHS/ACYF	1	-	1	1	-	1	1	-	1
Total:	**96**	**14**	**110**	**96**	**14**	**110**	**96**	**14**	**110**
Office of Rural Health Policy:									
Direct:									
Outreach	2	-	2	2	-	2	2	-	2
Radiogenic Diseases	1	-	1	1	-	1	1	-	1
Policy Development	1	-	1	1	-	1	1	-	1

Programs	2012 Actuals Civilian	2012 Actuals Military	2012 Actuals Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
State Offices	1	-	1	1	-	1	1	-	1
Rural AED	2	-	2	2	-	2	-	-	-
Telehealth	1	-	1	1	-	1	1	-	1
Rural Hospital Flexibility Grants	1	-	1	1	-	1	1	-	1
Total:	**9**	-	**9**	**9**	-	**9**	**7**	-	**7**
Family Planning (Direct)	25	8	33	25	8	33	25	8	33
Program Management (Direct)	780	82	862	771	82	853	773	82	855
Subtotal Reimbursables (non add)	79	8	87	85	8	93	85	8	93
Subtotal Direct (non add)	1600	207	1807	1594	207	1801	1572	207	1779
Total	**1679**	**215**	**1894**	**1679**	**215**	**1894**	**1657**	**215**	**1872**

Average GS Grade

FY 2010	12.50
FY 2011	12.50
FY 2012	12.50
FY 2013	12.50
FY 2014	12.50

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2014 Budget Request. Termination of these programs frees up approximately $43.1 million (discretionary) and $55 million (mandatory) based on the FY 2012 levels for priority health programs that have demonstrated a record of success or that hold significant promise for increasing accountability and improving health outcomes. Following each program is a brief summary and the rationale for its elimination.

Program	FY 2012 Dollars in Millions
Discretionary	
Health Careers Opportunity Program	$ 14.8
Area Health Education Centers	$ 27.2
Rural & Community Access to Emergency Devices	$ 1.1
Total Discretionary	**$ 43.1**
Mandatory	
School-Based Health Centers - Facilities	$50.0
Family to Family Health Information Centers	$ 5.0
Total Mandatory	**$ 55.0**

Program Descriptions

Discretionary

Health Careers Opportunity Program (-$14.8 million)

Although increasing diversity in the health professions is a high priority, the Budget includes funding directed to building the capacity and training of the primary care workforce.

Area Health Education Centers (-$27.2 million)

Although expanding the dispersal of health professions trainees is a high priority, the Budget includes funding directed to building the capacity and training of the primary care workforce.

Rural & Community Access to Emergency Devices (-$1.1 million)

Activities related to access to emergency medical devices and training in FY 2013 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs.

Mandatory

School-Based Health Centers(SBHC) - Facilities: (-$50.0 million)

The Affordable Care Act does not authorize an appropriation amount for FY 2014. The SBHC facility authorized and appropriated in FY 2010 through FY 2013 is available until expended. Program projects that all appropriated SBHC Facility funding will be expended by the end of FY 2013.

Family to Family Health Information Centers: (-$5.0 million)

Centers disseminating family based information may work through state and FQHCs to implement medical/health homes without separate Federal MCH funding.

Health Professions Loan Programs

HRSA is responsible for the administration of the following revolving loan programs: Health Professions Student Loan (HPSL) Program, the Nursing Student Loan (NSL) Program, Loans for Disadvantaged Students (LDS), and the Primary Care Loans (PCL).

These programs were initially financed through appropriations to the revolving loan funds. Appropriations ceased in 1984.

These programs are financed through revolving accounts (Federal Capital Contribution) and do not receive annual appropriations. Through these revolving fund accounts, the HPSL, PCL, LDS, and NSL programs award funds to institutions that in turn provide loans to individual students. As borrowers pay back loans the program's revolving account gets replenished, and the collected funds are then used to make new loans in the following academic year. If the program's revolving account has excess funds that will not be used to provide new loans, these excess funds are returned to HRSA. Funds returned to HRSA are then awarded to programs that are in need of additional funds. Therefore, the funding awarded each year fluctuates and is dependent upon the amount of loans repaid into the revolving account. The HPSL, PCL, LDS, and NSL programs aim to expand high-quality educational opportunities to those students, including racial and ethnic minorities and disadvantaged students, who otherwise could not afford a health professions education.

The information below reflects preliminary data for Academic Year 2011-2012 and was derived from the 2012 Annual Operating Report.

	Number of Programs[209]	Number of Borrowers	Account Balance
HPSL	157	33,364	$378,701,815
PCL	127	3,684	$246,664,915
LDS	175	7,342	$130,836,447
NSL	348	43,786	$171,324,184
Total	807	88,176	$927,527,361

New Awards in Academic Year 2011-2012 were as follows:

	Number of New Loans	Amount of New Funds Awarded
HPSL	13,175	$52,181,890
PCL	355	$19,346,027
LDS	2,423	$11,842,889
NSL	10,754	$27,421,763
Total	26,707	$110,792,569

[209] Programs refer to the number of disciplines (e.g., allopathic medicine, nursing, etc.) that maintained a revolving fund account)

Drug Budget

Dollars in Millions	2012	2013	2014
Bureau of Primary Health Care (BPHC)			
Health Centers Program (discretionary)	$10	$10	$11
Health Center (mandatory)	$8	$8	$7
Total	**$18**	**$18**	**$18**

Source: Estimates based on 2011 HRSA Health Centers information reported in the Uniform Data System (UDS) on their patient services, revenues and expenditures

Methodology Discussion: The Uniform Data System (UDS) tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected from grantees and reported at the grantee, state, and national levels. The UDS reporting provides a reasonable basis for estimating the share of the Primary Health Care Grants used for substance abuse treatment. Using the data reflected on table 8A Financial Costs in the 2011 UDS report, 0.73% represents the dollars expended by health centers on substance abuse in 2011 divided by the total cost of all services provided. To calculate the total drug control estimates, 0.73% is multiplied by the amount of Health Center Program grant dollars awarded to health centers in FY 2012, and the projected amount of Health Center Program grant dollars to be awarded to health centers in FY 2013 and FY 2014

	2012	2013	2014
Drug Resources – Health Center Program			
Prevention	$4	$4	$4
Treatment	$14	$14	$14
Total, Drug Resources	**$18**	**$18**	**$18**

Significant Items

TAB

HEALTH RESOURCES AND SERVICES ADMINISTRATION

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATION COMMITTEE REPORTS

The following section represents FY 2013 Congressional requirements for reports and significant items derived from Senate Report 112-176

FY 2013 Senate Appropriations Committee Report Language (Senate Report 112-176 and Senate Report 112-84)

Item 1

Community Health Centers -The administration proposes obligating only $1,220,000,000 of the fiscal year 2013 mandatory funding for this program in fiscal year 2013, leaving $280,000,000 to be awarded in later years. The Committee feels strongly that the congressional intent of the PPACA funding for community health centers was to enable individuals possessing affordable health insurance for the first time in 2014 to have as many entry points to the healthcare system as possible. For that reason, the Committee includes a new statutory provision requiring HRSA to award all fiscal year 2013 funds by September 30, 2013. Such awards shall include $48,000,000 in base grant adjustments to ensure that existing centers are surviving and thriving, even as new centers come online. (Page 42)

Action Taken or To Be Taken

HRSA will administer programs and activities according to the congressional direction and funding provided in the final FY 2013 appropriation. However, the FY 2013 Budget Request promotes a long-term strategy to manage mandatory resources appropriated to Health Centers through Section 10503 of the ACA. This strategy will promote steady and sustainable Health Center growth.

Item 2

Native Hawaiian Health Care - The Committee includes sufficient funding in the community health centers program to support healthcare activities funded under the Native Hawaiian Health Care Program, which is specifically cited in the bill. The Committee expects that not less than the fiscal year 2012 level be provided for these activities in fiscal year 2013. (Page 43)

Action Taken or To Be Taken

HRSA will administer the Native Hawaiian Health Care Program according to the Congressional direction and funding level provided in the final FY 2013 appropriation.

Item 3

Primary Care Training and Enhancement - This program supports the expansion of training in internal medicine, family medicine, pediatrics, and physician assistance. Funds may be used for developing training programs or providing direct financial assistance to students and residents. The Committee once again urges HRSA to prioritize the training of physician assistants and includes bill language allowing HRSA to determine the funding amount for this activity.

The Committee is troubled that the HRSA guidance for this program currently prevents schools from applying for a grant unless they are fully accredited. Training programs cannot gain full accreditation until they are already up and running. By restricting the grant competition to training programs with full accreditation, HRSA is precluding one of two major goals of this grant program--increasing the number of new primary care training programs. The Committee directs HRSA to change its guidance in fiscal year 2013 to allow funds to be used to develop a training program and apply for accreditation.
(Page 45)

Action Taken or To Be Taken
At this time, we are unable to determine if we have resources to offer a new FY 2013 funding opportunity for physician assistant programs in the Primary Care Training and Enhancement Program. Note, however, that the language in the Senate Appropriation Committee Report misstates the Bureau of Health Profession's policy regarding accreditation. If the applicant is provisionally accredited, then full accreditation is not required for eligibility. Consistent with Section 799B(1)(E) of the Public Health Service Act, the PCTE-PATC Funding Opportunity Announcement released on March 20, 2012 specifies that eligible applicants for the PATC program include both accredited and provisionally accredited public or nonprofit private hospitals, schools of allopathic or osteopathic medicine, and academically affiliated PA training programs. The provisionally accredited applicant must demonstrate in its application that full accreditation is expected during the grant's project period. Section 799B(3) of the PHS Act provides that a "physician assistant education program" is one that "is accredited by the Accreditation Review Commission on Education for the Physician Assistant [(ARC-PA)]." ARC-PA allows programs that are provisionally accredited to operate. Accordingly, HRSA adheres to ARC-PA's determinations when deciding whether an entity is eligible for the PATC program.

Item 4
Area Health Education Center - The Committee recognizes the importance of community health workers in addressing the health needs of individuals who may not have access to regular healthcare services. The AHEC community training model provides a uniquely appropriate opportunity to bring the training of community health workers to scale. HRSA is encouraged to provide technical assistance on and disseminate best practices for training community health workers to existing AHECs. (Page 46)

Action Taken or To Be Taken
HRSA recognizes the important role of community health workers in increasing access to services for vulnerable populations, and increasing support for direct service workers. HRSA fosters community health worker training efforts implemented by Area Health Education Centers programs across the nation and provides technical assistance through various venues – including special webinars.

One recent example of HRSA's efforts to further enhance the role of community health workers is our collaboration with Substance Abuse and Mental Health Services Administration and the Office of the Assistant Secretary of Health for a pilot project - *Community Health Worker –*

Behavioral Health Primary Care Integration Project. This program provides significant opportunities for national dissemination and replication.

Item 5

Public Health and Preventive Medicine Training Programs - The Committee recommendation includes $5,420,000 for preventive medicine residencies and $5,000,000 for integrative medicine residencies. The fiscal year 2012 level for integrative medicine residencies is $3,000,000. The increase provided in the Committee recommendation is intended to expand the national technical assistance and evaluation activities. (Page 46)

Action Taken or To Be Taken

While the funding levels for FY 2013 have yet to be finalized, HRSA will consider the committee's recommendation.

Item 6

Nursing Workforce Development Program - The Committee is concerned that many nursing education and training programs are unable to guarantee required clinical placements to students who have completed the appropriate classroom work. These individuals remain full-time students longer than otherwise necessary, accumulating more student loan debt, while they await placement for their required clinical rotation. The Committee directs HRSA to prioritize applications for nursing education and training programs that provide incoming freshman students with a guarantee of high-quality clinical placements in hospitals, nursing homes, visiting nurse programs, and other care settings during their junior and senior years of study. (Page 48)

Action Taken or To Be Taken

HRSA recognizes the importance of ensuring that nursing students have access to high-quality clinical placements. In HRSA's Workforce Development Programs, applicants that can demonstrate student placement for field or practicum sites serving rural or underserved populations receive a funding preference. HRSA is exploring other opportunities for emphasizing clinical placements for nursing students.

Item 7

Vision and Eye Health - The Committee is concerned that 1 in 4 school-aged children has a vision problem significant enough to affect learning. Many serious ocular conditions in children are treatable if diagnosed at an early stage. The Committee encourages HRSA to continue to support the development of a public health infrastructure to promote a comprehensive continuum of vision care for children through strong partnerships, sound science, and targeted policy initiatives. (Page 49)

Action Taken or To Be Taken

HRSA continues to support the National Center for Children's Vision and Eye Health at Prevent Blindness America (PBA). The Center supports the development of a public health infrastructure to promote and ensure a comprehensive, multi-tiered continuum of eye health and vision care for young children. The Center serves as a resource for vision screening education, training and certification, family support resources, communication tools, and technical assistance. Most recently, the Center has produced recommendations for screening children aged 36 to <72 months for vision disorders, primarily amblyopia, strabismus, significant refractive error, or risk factors associated

with these disorders. The Center will continue to work with states to implement vision screening for all children aged 36 to <72 months.

Item 8

Autism and Other Developmental Disorders - The Committee directs HRSA to fund research on evidence-based practices for interventions for individuals with autism and other developmental disabilities, for development of guidelines for those interventions, and for information dissemination at no less than fiscal year 2012 levels. (Page 50)

Action Taken or To Be Taken

Under the Combating Autism Act Authority, HRSA supports three autism intervention research networks that conduct research on evidence-based practices, develop and update guidelines for interventions, and disseminate information to health professionals and the public. These research networks also enhance the further development of the field by supporting the development and mentorship of new investigators in the field of autism spectrum disorders (ASD) research and fostering the transfer of findings into practice and communities.

- The Autism Intervention Research Network on Physical Health (AIR-P Network) has implemented fifteen research protocols to improve the physical health of children and adolescents with ASD. AIR-P has developed and published three clinical guidelines addressing insomnia, constipation and medication choice, some of the most common physical health and related issues that children and adolescents with ASD and their families experience. Further development of guidelines addressing neurology, genetics and metabolic screening decisions are in progress.

- The Autism Intervention Research Network on Behavioral Health (AIR-B Network) has implemented four research protocols focusing on core deficits in autism being conducted in natural environments that focus on underserved or under-represented populations. The AIR-B has developed a consensus-based guidelines report assessing the scientific evidence on behavioral, educational, and medical interventions and their impact on ASD symptoms.

- The Developmental-Behavioral Pediatrics Research Network (DBPNet) has developed the national research agenda for Developmental-Behavioral Pediatrics research. Current research includes studies on clinical practice variation and feasibility of electronic health record data in describing clinical practice. DBPNet has completed a study on research training in DBP fellowship programs. The DBPNet fosters the development of new investigators in developmental-behavioral pediatrics by providing opportunities for new investigators to conduct research with mentorship from senior investigators across the network. DBPNet continues to strengthen the DBP research infrastructure by fostering the development of the next generation of DBP researchers, supporting research opportunities for its Network investigators, and promoting collaboration with and involvement of interdisciplinary researchers to advance the health and well-being of children and adolescents with ASD and other developmental disabilities.

In addition to the research networks, HRSA's R40 Autism Intervention Research Grant Program supports applied investigator-initiated research projects and secondary data analysis studies to improve the evidence-base for interventions for children and adolescents with ASD and their families. The portfolio of R40 projects includes 27 R40 grants addressing key areas examining areas of particular interest to families and many addressing the needs of underserved populations.

Significant R40 research projects explore identification and diagnosis of ASD among Latino families, intervention strategies for improving the health care transition for youth with ASD, a culturally compatible parent to parent model of support and service coordination for families with a preschool child with ASD, and teleconsultation training for parents to perform applied behavior analysis (ABA) therapy for their rural, underserved children with ASD.
HRSA'S autism intervention research programs have achieved broad dissemination of their research and related findings to providers, researchers, communities and families. To date, 57 peer-reviewed articles have been published in leading journals such as Pediatrics and JAMA. In addition to peer-reviewed publications, other dissemination includes development of websites by all three research networks, an AIR-B online wiki knowledgebase, presentations and abstracts at local, national and international conferences, collaboration with other stakeholders such as Autism Speaks, webinars and videos.

Item 9

Newborn Screening and Heritable Disorders - The Committee encourages HRSA to collaborate with and support non-governmental entities that help educate and support States as they consider expanding their screening panels. The Committee believes that this activity is beneficial to the existing efforts of HRSA. (Page 50)

Action Taken or To Be Taken

HRSA actively engages with non-governmental entities through grants, workgroups and work of the Advisory Committee. Examples of this engagement include:

- The Newborn Screening Technical Assistance center to the State newborn screening programs is funded through a cooperative agreement. The awardee is the Association of Public Health Laboratories (APHL).
- The legislated clearinghouse of newborn screening information is funded as a cooperative agreement. The awardee is the Genetic Alliance.
- Each subcommittee to the Advisory Committee includes representatives from various stakeholder groups, such as the March of Dimes' involvement in the Laboratory Standards and Procedures Subcommittee, the Genetic Alliance' participation in the Education and Training Subcommittee and the American College of Medical Genetics' participation in the Laboratory Standards and Procedures Subcommittee. The work of these subcommittees is to develop guidance and provide recommendations to the Advisory Committee which in turn is provided for reference by the State newborn screening programs.
- Workgroups to support the States also include the non-governmental groups, such as the funded projects to develop case definitions which were led by APHL, with participation by the Genetic Alliance and the American College of Medical Genetics and Genomics.

Item 10

Healthy Start - The Committee continues to encourage HRSA to support efforts to evaluate and address racial disparities in stillbirth and sudden unexpected infant deaths. The Committee expects HRSA to give full and fair consideration to all applicants, including grantees with expiring or recently expired project periods. (Page 51)

Action Taken or To Be Taken

There continues to be disparities in birth outcomes in the United States. African American babies die before their first birthday at a rate of more than two times that of white babies. The causes of stillbirths and the best way to prevent their occurrence have not been well defined, and Sudden Unexpected Infant Death (SUID) continues to be a significant cause of infant mortality. As directed in legislative language, Healthy Start continues to address disparities in birth outcomes, including stillbirth and SUID. Healthy Start provides resources and technical assistance to communities with high rates of stillbirth and SUID. Many of these communities have a majority target population of African Americans, American Indians, and Latinas. The lessons learned from Healthy Start activities are used to further refine and adapt the program to meet the needs and challenges of these populations around these specific health topic areas.

HRSA held a competition in FY 2012 and gave full and fair consideration to all applicants for Healthy Start funding. This was accomplished through an Open Competition where all applications were reviewed by an Objective Review Committee comprised of content matter experts, overseen by HRSA's Division of Independent Review. Healthy Start grantees are all non competing continuations in FY 2013 and no competition will be held.

Item 11

Emergency Medical Services for Children - The Committee is particularly concerned by the low availability of pediatric emergency medical services in rural and remote areas and urges HRSA to give priority to applicants who propose a focus on populations in these areas. To the extent possible, HRSA should work with other Federal agencies that have an interest in expanding emergency systems in rural and remote areas. (Page 51)

Action Taken or To Be Taken

In June 2012, the EMSC Program awarded six State Partnership Regionalization of Care grants to address the limited and delayed access families and children in tribal, territorial, insular, and rural areas experience due in large part to geography and the lack of resources. The Program launched this regionalization project to support state-efforts to reach beyond their borders to overcome barriers to specialized pediatric medical and trauma services. These projects will establish a process to manage and treat acutely ill and severely injured children in isolated areas through Agreements of Consultation, Telemedicine, and other innovative approaches; facilitate access to and retrieval of clinical data to provide safe, more timely, efficient, effective, equitable, and patient-centered care; develop models for regionalized care that could be adapted in other rural areas or even applied to disaster preparedness; establish collaborations and partnerships beyond state borders to efficiently and effectively improve the quality and access to specialized pediatric medical services for the populations of focus in the tribal, U.S. territorial, insular, and rural areas; and identify technology and network infrastructures that will create the desired integration.

The EMSC Program also works in partnership with federal working groups such as the inter-agency coordinating body for telemedicine, FedTel and the HHS Workgroup on Native Hawaiians and Pacific Islanders, as well as the Indian Health Services, the Office of Global Health Affairs, and the National Association of State EMS Officials to assure ongoing collaboration and integration to address the needs of the pediatric populace in the most isolated areas.

Item 12

Comprehensive Care Programs - The Committee includes bill language providing $963,299,000 for AIDS medications in ADAP. The fiscal year 2012 comparable level is $933,299,000 and the budget request is $1,000,000,000. The Committee intends that the increase provided for ADAP be awarded according the statutory formula. The Committee encourages HRSA to engage in a process with States to determine the best allocation for the past emergency funds based upon the growth of the program and cost containment measures in place as of January 1, 2013. (Page 52)

Action Taken or To Be Taken

HRSA will continue to allocate emergency funds based on critical need in states. New increases will be awarded according to statute.

Item 13

Organ Donation and Transplantation - The Committee encourages the Division of Transplantation and the United Network for Organ Sharing to continue their dialogue with experts regarding the methodology used to determine lung transplantation eligibility for pulmonary hypertension patients. (Page 53)

Action Taken or To Be Taken

At its November 2012 meeting, the OPTN Board of Directors approved changes to calculation of the Lung Allocation Score (LAS), which is the primary factor in prioritizing organ offers for lung transplant candidates. The updated LAS is expected to balance priority for all groups of candidates and particularly provide more accurate assessment of the medical needs of candidates with pulmonary hypertension.

Prior to approval by the OPTN Board of Directors the policy proposal to revise the LAS system (OPTN Policy 3.7.6) was released for a 90-day public comment period beginning on March 16, 2012. One provision of the proposal, which was developed by the OPTN Thoracic Organ Transplantation Committee (the Committee) was to include the addition of a bilirubin laboratory value to better address the hemodynamic decompensation of certain candidates for lung transplantation diagnosed with pulmonary hypertension. The pulmonary hypertension community widely supported the proposal with over 250 people from the pulmonary hypertension community submitting favorable comments, including suggestions that the proposed policy change would address shortcomings of the current LAS system that may not fully identify and accurately reflect an increase in waiting list mortality associated with an acute worsening of candidates with pulmonary hypertension. The response rate to this request for public comment was particularly high due to the social media efforts initiated by pulmonary hypertension support groups, including the Pulmonary Hypertension Association.

The approved change to the OPTN lung allocation policy is pending programming into the OPTN computer system. It is expected the policy change will be effective by Spring 2014.

Item 14

Office of Pharmacy Affairs - The Committee remains strongly committed to the Office's plans to develop a transparent system to verify the accuracy of the 340B ceiling price. Therefore, the Committee includes a statutory provision, requested by the administration, to allow a nominal cost recovery fee to fund the implementation of program integrity provisions recommended by the Inspector General and included in PPACA. The fee will be set at 0.1 percent for covered entities and is expected to generate $6,000,000 in fiscal year 2013. The Committee expects HRSA to report the expected and actual amounts generated by the fee in HRSA's annual budget justification. (Page 54)

Action Taken or To Be Taken

The 340B cost recovery fee system will establish the necessary requirements for manufacturers and covered entities to efficiently administer this cost recovery system that will provide operations, oversight and integrity for the 340B Drug Pricing Program. The cost recovery fee, in addition to OPA's line item budget, will support the natural growth of the 340B Program and fund new authority, responsibilities, and oversight. The cost recovery fee of 0.1 percent would be calculated on and added to the price of the 340B drug. Covered entities would have to pay the user fee to continue to participate in the 340B Program. The fee would be collected on a periodic basis directly from the entity based on purchase information from drug manufacturers and submitted to the Treasury into an account that HRSA would use to operate the 340B Program and undertake program integrity activities. (The manufacturer does not pay the fee and is not responsible for unpaid fees.) These activities include beginning: development of the cost recovery system; development of an on-line, secure system to post 340B ceiling prices for access by participating covered entities; establishment of an administrative dispute resolution process for claims of overcharges; and establishment of civil monetary penalties for manufacturers who overcharge or covered entities who intentionally divert drugs to ineligible patients.

HRSA will report on the progress of these initiatives:

340B Ceiling Price Regulations
340B Cost Recovery System
340B Civil Monetary Penalties for Covered Entities
340B Civil Monetary Penalties for Manufacturers
340B Drug Pricing Program; Administrative Dispute Resolution Process

Item 15

Audit Procedure - Audit Procedure- The Committee commends HRSA for conducting audits of covered entities and recertifying eligibility for all program participants in an effort to ensure 340B program integrity. The Committee is aware that HRSA recently published a program notice that referenced an audit protocol to be made public at a later date. Given that the audit process is well underway, the Committee urges HRSA to make public information on the general audit process, including areas of review, as soon as possible and consider suspending audits until this information is publicly available. (Page 54)

Action Taken or To Be Taken

HRSA, in addition to the program notice previously released, has created a page on the Office of Pharmacy Affairs website which outlines the audit process from pre-audit to post audit. The website further specifies a number of audit procedures performed while the HRSA auditor is on-site. The information can be found at http://www.hrsa.gov/opa/programintegrity/auditscopeandprocess.html.

Item 16

Family Planning Comprehensive Services - The Committee is aware that Title X clinics have been denied designation as National Health Service Corps sites, under the reasoning that they do not provide referral to comprehensive primary care services. However, the Committee notes that all Title X grantees are required to certify that they provide, or provide referral to, a full range of primary care services. If HRSA is sufficiently satisfied that a Title X clinic provides ''comprehensive primary care services'', the Committee believes that should satisfy the identical requirement in other HRSA programs. The Committee directs HRSA to align the definition of ''comprehensive primary care services'' in Title X and the National Health Service Corps. In addition, the Committee directs the Secretary to provide guidance to title X-only funded grantees about how to meet the requirements to receive assignment of National Health Service Corps personnel.

Action Taken or To Be Taken

The National Health Service Corps (NHSC) does consider Title X Family Planning-funded health clinics eligible to participate in the NHSC, so long as they meet the same set of requirements placed on all NHSC service sites, including the provision of comprehensive primary care services on site or by referral. In the past, Title X-funded health clinics did experience challenges in demonstrating compliance with this NHSC requirement; however, many Title X-funded health clinics currently do provide many primary care services on site, and refer patients to a full range of comprehensive primary care services. There are many types (i.e., practice models) of Title X-funded health clinics. Some are stand-alone clinics offering family planning and a subset of related primary care services, while others offer a wider range of primary care services. Many of these clinics have established networks or affiliations with other institutions providing a full range of services and are eligible to be NHSC sites.

HRSA has clarified its policy that evidence of referral agreements for comprehensive primary care services would be considered as meeting the requirements, and as a result, some Title X-funded health clinics have been deemed eligible. Specifically, as part of an effort to ensure the greatest scope of services are available to individuals in underserved communities at NHSC-approved sites or through referral networks, in March 2012, a revised NHSC Site Reference Guide clarified the definition of comprehensive primary health services to mean the delivery of preventive, acute and chronic primary health services in an NHSC-approved specialty (e.g., adult, family, internal medicine, general pediatric, geriatrics, general psychiatry, mental and behavioral health, women's health, and obstetrics/gynecology). The Guide also explains that if sites do not offer all primary health services they must offer an appropriate set of primary health services necessary for the community and/or populations they serve. Sites must provide documentation and meaningful demonstration of appropriate referral networks for other preventive, acute, and chronic primary health services with other NHSC-approved sites or

providers. In March 2012, HRSA hosted an educational webinar for women's health providers including Title X-funded agencies to discuss this refined policy and is currently providing technical assistance on a case-by-case basis to Title X-funded agencies that request such assistance or at time of NHSC-site application. Since the issuance of the revised Site Reference Guide, HRSA has approved applications from Title X-funded agencies to become NHSC-approved services sites.

Item 17

Family Planning Program Guidance - The Committee supports efforts to review and update the Title X program guidance and administrative directives. In particular, the Committee requests that the guidance clarify that Title X funds may be used for clinic training on and implementation of information technology systems, including electronic medical records. The Secretary is encouraged to complete the guideline revisions in 2012 to enable the publicly supported family planning network to sufficiently prepare for the changing healthcare delivery system.

Action Taken or To Be Taken

The Office of Population Affairs (OPA) and the Centers for Disease Control and Prevention anticipate the release of updated Title X program guidelines in 2013. The guidelines have not been updated since 2001. The two-part update will consist of Title X program requirements (statutes, laws, and regulations that govern the program) and guidance for the delivery of clinical family planning services. This update reflects input from a work group comprised of subject matter experts including representatives from medical associations, government agencies, family planning organizations, and the research community.

OPA also recognizes the role of health information technology (HIT) in the health care system. HIT is one of the five priority areas identified by OPA for the Title X program in FY 2012 and FY 2013. In 2010, OPA funded a survey of providers to determine their status with regard to updating their information systems. The survey revealed that while some providers were gearing up for the transition, many were unprepared. Since then, OPA has sponsored a number of webinars featuring the Office of the National Coordinator for Health IT (ONC) and the Regional Extension Centers (RECs), and continues to work with HHS regional staff to communicate the importance of incorporating HIT to the Title X grantees they monitor. OPA is developing a competitive FOA to make a small amount of funding, approximately $2.5 million, available to grantees to purchase or upgrade their HIT systems. Nevertheless, we anticipate that challenges will remain for many organizations seeking to address their HIT needs given overall resource constraints. Additionally, in some cases the family planning program is part of a larger health agency and is not in control of decision-making. OPA continues to work with providers to educate them about the resources that are available for implementing upgrades to HIT systems and working toward adoption of electronic health records.

Item 18

Health Education Assistance Loans Program - The Committee includes a general provision (section 522) to transfer the administration of the HEAL program to the Department of Education, as requested by the administration. (Page 57)

Action Taken or To Be Taken

HRSA worked with the Department of Education to provide its staff with information about the HEAL program, including budget models, contracts, personnel requirements, laws, regulations and policies and IT systems.

Item 19

Nursing -The Committee is aware that the Institute of Medicine [10M] report "The Future of Nursing: Leading Change, Advancing Health" made a series of important recommendations to advance nursing practice, education, leadership and workforce data as well as promote inter-professional education and collaboration. The Committee encourages the Secretary to develop an implementation plan regarding these recommendations, in collaboration with CMS and HRSA, and provide the Committee with an update on its progress in the fiscal year 2013 congressional budget justification. (Page 155)

Action Taken or To Be Taken

The Department recognizes the critical role that interprofessional education and collaborative practice play in bringing the full training, skills, and expertise of nurses and all health care team members to the delivery of high-quality cost-effective care. In 2011 HRSA co-sponsored an invitational conference of Interprofessional Education Consortium to determine core competencies in team-based care and interprofessional education. In FY 2012 HRSA awarded a cooperative agreement to the University of Minnesota to establish a National Center for Interprofessional Education and Practice to provide the infrastructure for support to enhance the coordination and capacity building of interprofessional education and collaborative practice. Augmenting those efforts, HRSA funding opportunity announcements for the Advanced Nursing Education and the Nurse Education, Practice, Quality and Retention programs in FY 2012 and 2013 solicited applications focused on interprofessional education and collaborative practice initiatives. The Department also recognizes that effectively advancing the nation’s healthcare workforce depends upon a nimble, timely, and high-utility data infrastructure on the supply, skills, and distribution of the nation’s workforce. HRSA’s National Center for Healthcare Workforce Analysis has collaborated with other governmental and private sector partners in developing a robust enterprise of data resources and reports to inform federal health workforce policy and its funding initiatives.

Health Education Assistance Loans
Tab

Health Education Assistance Loans

Table of Contents

FY 2014 Budget

APPROPRIATIONS LANGUAGE

Such sums as may be necessary to carry out the purpose of the program, as authorized by title VII of the PHS Act. In addition, for administrative expenses to carry out the guaranteed loan program, including section 709 of the PHS Act, ($2,807,000) *$2,807,000*. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Amounts Available for Obligation
Program and Financing Accounts

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 PB
Balance, start of year	$69,244,000	$ 49,474,548	-
Appropriation	2,807,000	2,853,000	-2,807,000
Total Appropriation	2,807,000	2,853,000	-
Collections:			
Upward Re-estimate		56,000,000	-
Downward Re-estimate	-12,020,000		
Interest	3,739,000	2,881,000	
Repayments/Recoveries	7,029,000	4,083,000	
Total collections	-1,252,000	62,964,000	-
Borrowing Authority, Mandatory			
Total available	70,799,000	115,291,548	-
Claims:			
Death and disability	-1,496,000		-
Defaults	-16,930,000	-13,000,000	
Total claims	-18,426,000	-13,000,000	
Principle Payments on Borrowing	-91,452		
Administrative BA	-2,807,000	-2,853,000	
Ending balance	$49,474,548	$99,438,548	

Liquidating Account

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 PB
Balance, start of year	---	---	---
Appropriation	$1,000,000	$1,000,000	-
Collections:			
Repayments/Recoveries	7,941,000	7,845,000	-
Total available	8,941,000	8,845,000	-
Total claims	-3,476,000	-3,478,000	-
Sweep-up to Treasury	$5,465,000	$5,367,000	-

Summary of Changes

Discretionary Appropriation:		
Increase:	**FTE**	**BA**
2012 HEAL Program Account	13	$2,807,000
2014 HEAL Program Account	-	-
Total Change	-13	-$2,807,000

Budget Authority by Activity

(Dollars in thousands)

	FY 2012 Enacted	**FY 2013 Annualized CR**	**FY 2014 PB**
Liquidating Account SLIA	$1,000,000	$1,000,000	-
HEAL Program Account:			
Administrative Expenses	$2,807,000	$2,853,000	-

Budget Authority by Object

Liquidating Account

Object Class (33.0)	**FY 2012 Enacted**	**FY 2014 Estimate**	**Increase or Decrease**
Investments and loans	$1,000,000	--	-$1,000,000

Budget Authority by Object
Program Account

	FY 2012 Enacted	FY 2014 Estimate	Decrease or Increase
Full-time equivalent employment 1/	12.5	12.5	-
Average GS Grade	12.5	12.5	-
Average GS Salary	$84,800	$84,855	55

1/ Includes 7 FTEs for the Office of HEAL Default Reduction.

Personnel compensation:	**FY 2012 Enacted**	**FY 2014 Estimate**	**Decrease**
Full-time permanent (11.1)	$1,259,000	-	-$1,259,000
Other than full-time perm (11.3)			
Other personnel comp (11.5).			
Total personnel comp (11.9)	**$1,259,000**	**-**	**- $1,259,000**
Personnel benefits (12.1)	304,000	-	-304,000
Benefits for Former Personnel(13.1)			
Subtotal Pay Costs.	**$1,563,000**	**-**	**-$1,563,000**
Travel and transportation of Persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	152,000	-	-152,000
Printing (24.0)		-	
Other Contractual Services:			
Other services (25.2)	1,090,000	-	-1,090,000
Purchase of goods and services from other Government accounts (25.3)		-	
Operation and Maintenance of Equipment (25.7)		-	
Discounts and Interest (25.9)			
Supplies and Materials (26.0)	2,000	-	-2,000
Subtotal Other Contractual Services	**$1,244,,000**	**$-**	**-$1,244,,000**
Equipment (31.0)			
Total Budget Authority by Object Class.	**$2,807,000**	**$-**	**-$2,807,000**

Salaries and Expenses

Personnel compensation:	FY 2012 Enacted	FY 2014 Estimate	Increase or Decrease
Full-time permanent (11.1)	$ 1,259,000	$-	- $ 1,259,000
Other than full-time perm (11.3)			
Other personnel comp (11.5).			
Total personnel comp (11.9)	**$1,259,000**	**-**	**- $1,259,000**
Personnel benefits (12.1)	304,000	-	-304,000
Benefits for Former Personnel(13.1)			
Subtotal Pay Costs.	**$1,563,000**	**-**	**-$1,563,000**
Travel and transportation of persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	152,000	-	-152,000
Printing (24.0)			
Other Contractual Services:			
Other services (25.2)	1,090,000	-	-1,090,000
Purchase of goods and services from other Government accounts (25.3)			
Operation and Maintenance of Equipment (25.7)			
Discounts and Interest (25.9)			
Supplies and Materials (26.0)	2,000	-	-2,000
Subtotal Other Contractual Services	1,092,000	-	-1,092,000
Subtotal Non-Pay Cost	**$1,244,000**	**-**	**-$1,244,000**
Total Salaries and Expenses	**$2,807,000**	**-**	**-$2,807,000**

Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2014 Pres. Budget
Health Education Assistance Loans and Student Loan Insurance Account:				
Appropriation:				
Liquidating Account (SLIA):				
PHS Act, Sec. 710	---[210]	1,000,000	---[210]	---
Program Account:				
PHS Act, Secs. 709, 720	SSAN[211]	2,807,000	SSAN	---
Borrowing authority (SLIA):				
PHS Act, Sec 710(b)	---[212]	---	---	---

[210] Sec 710(a)(2) states, "Except as provided in subparagraph (B), all amounts received by the Secretary as premium charges for insurance and as receipts, earnings, or proceeds derived from any claim or other assets acquired by the Secretary in connection with his operations under this subpart, and any other moneys, property, or assets derived by the Secretary from the operations of the Secretary in connection with this section, shall be deposited in the Account."

[211] Such Sums as Necessary

[212] Sec 710(b) states, "If at any time, the moneys in the Account are insufficient to make payments in connection with the collection or default of any loan insured by the Secretary under this subpart, the Secretary of the Treasury may lend the Account such amounts as may be necessary to make the payments involved, subject to the Federal Credit Reform Act of 1990."

APPROPRIATION HISTORY
HEAL Program Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2005	3,270,000	3,270,000	3,270,000	3,270,000
Rescission				-26,000
2006	2,916,000	2,916,000	2,916,000	2,916,000
Rescission				-31,000
2007	2,887,000	2,887,000	2,887,000	2,898,000
2008	2,906,000	2,906,000	2,906,000	2,847,000
2009	2,847,000	2,847,000	2,847,000	2,847,000
2010	2,847,000	2,847,000	2,847,000	2,847,000
2011	2,841,000	2,841,000	2,841,000	2,841,000
2012	2,841,000	2,841,000	2,841,000	2,841,000
Rescission				-34,000
2013	2,807,000	2,807,000	2,807,000	2,853,000
2014	-----			

Liquidating Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2002	10,000,000	10,000,000	10,000,000	10,000,000
2003	7,000,000	7,000,000	7,000,000	7,000,000
2004	4,000,000	4,000,000	4,000,000	4,000,000
2005	4,000,000	4,000,000	4,000,000	4,000,000
2006	4,000,000	4,000,000	4,000,000	4,000,000
2007	4,000,000	1,000,000	1,000,000	1,000,000
2008	1,000,000	1,000,000	1,000,000	1,000,000
2009	1,000,000	1,000,000	1,000,000	1,000,000
2010	1,000,000	1,000,000	1,000,000	1,000,000
2011	1,000,000			1,000,000
2012	1,000,000	1,000,000	1,000,000	1,000,000
2013	1,000,000	1,000,000	1,000,000	1,000,000
2014	-----			

General Statement

Health Education Assistance Loans (HEAL)

To assist in training students in various health fields, the HEAL program was authorized to provide insured loans for students enrolled in schools of allopathic and osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, and graduate programs in health administration, clinical psychology and allied health.

Eligible student borrowers obtain loans, to be used for tuition and other reasonable educational and living expenses, from participating commercial lenders, educational institutions, State agencies, insurance companies and pension funds. The repayment of principal and interest is guaranteed by the Federal Government if the borrower becomes permanently disabled, dies, or defaults on the repayments.

Student Loan Insurance Account (SLIA)

The SLIA provides repayments to the lenders on defaulted HEAL loans, and for claims due to the death or disability of student borrowers. Deposits to the fund are derived from insurance premiums charged to the borrowers when the loans are made, repayments of defaulted claims, and if necessary, from borrowing authority and/or appropriations.

Health Education Assistance Loans

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Liquidating Account	$1,000,000	$1,000,000	--	-$1,000,000
HEAL Credit Reform-Direct Operations	$2,807,000	$2,853,000	--	-$2,807,000
FTE	13	13	--	-13

Authorizing legislation: Sections 701-720 of the Public Health Service Act
FY 2014 Authorization ..... Such Sums as Necessary
FY 2014 Authorization - Liquidating Account..... Such Sums as Necessary
Allocation Method .....Other

Program Goal and Description: The Health Education Assistance Loan (HEAL) Program insures loans made by participating lenders to eligible graduate students from 1978 through 1998. Authority to make new loans expired September 30, 1998 and refinancing ended September 30, 2004.

Need: The HEAL Program continues to maintain oversight for an outstanding loan portfolio valued at $609 million, some of which may not be fully repaid until 2037.

Eligible Entity: Designated health professions students.

Designated Health Professions:	Targeted Educational Levels:	HEAL Program Activities:
• Allopathic Medicine • Osteopathic Medicine • Dentistry • Veterinary Medicine • Optometry • Podiatry • Public Health • Pharmacy • Health Administration • Clinical Psychology • Chiropractic Medicine	• Graduate	• Monitor loan payback and pursue defaulters. • Maintain and publish list of defaulted borrowers. • Process lender claims and borrower requests for forbearance and disability and default reduction activities. • Provide technical assistance to States regarding licensing sanctions.

Program Accomplishments: Between 1978 and 1998, the program provided $4 billion in loans to help 157,000 students of diverse socio-economic backgrounds pay for their health professions education. Approximately $7.2 billion in HEAL loans were refinanced.

The HEAL Program maintains, and updates quarterly, a list of defaulted HEAL borrowers on the internet. This site includes approximately 933 health professionals who owe the Federal Government approximately $117.5 million on their defaulted HEAL loans as of February 2012. Millions of dollars have been received from defaulters as a result of the activities associated with publicizing their names.

In FY 2011, HEAL claims processing target of 8 days was exceeded. In FY 2013 and FY 2014, HEAL claims processing target lowered to 7 days. HEAL does not anticipate a 5 day processing time due to changes in personnel and complexity of cases.

Funding History

FY	Amount	Liquidating Account
2010	$2,847,000	$1,000,000
2011	$2,841,000	$1,000,000
2012	$2,807,000	$1,000,000
2014	--	--

Budget Request

The FY 2014 Budget Request is $0. The FY 2014 Request is $2,807,000 below the FY 2012 Enacted level. The Budget reflects the proposal to transfer the HEAL Program from the Department of Health and Human Services to the Department of Education.

The HEAL Program investment in IT supports the strategic and performance outcomes of the program and contributes to its success by providing a system that enables the Program to ensure data integrity, monitor adherence to legislation, meet regulatory or policy requirements and pay claims in the proper amounts. This investment automates borrower, loan, litigation, claim, school and lender information. The system allowed the HEAL Program to automate a large portion of the claim review process including the calculation of time periods mandated in legislation and regulation and computation of penalty periods. Administratively, the system provides management with approximately 100 reports used to monitor lender/servicer activity.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[213]/Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
9.VII.C.1: Conduct an orderly phase out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL Program (balance in the portfolio, dollars in millions). (Outcome)	FY 2011: $609 Target: $682 (Target Exceeded)	$567	$489	-$78
9.E: Improve claims processing efficiency through implementation of an online processing system (HOPS). (Av. Number of days to process claims)(Efficiency)	FY 2011: 5 days Target: 8 days (Target Exceeded)	8 days	7 days	-1 day

[213] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Vaccine Injury Compensation Program

TAB

Table of Contents

FY 2014 Budget Page

APPROPRIATION LANGUAGE

Vaccine Injury Compensation Program Trust Fund

For payments from the Vaccine Injury Compensation Program Trust Fund (``Trust Fund''), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed ($6,477,000) *$6,477,000* shall be available from the Trust Fund to the Secretary.
Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Amounts Available for Obligation

	FY 2012 Actual	FY 2013* Annualized CR	FY 2014* Estimate
Discretionary Appropriation:	$19,000,000	$19,000,000	$19,000,000
Mandatory Appropriation	185,000,000	235,000,000	235,000,000
Subtotal, adjusted appropriation……	$204,000,000	$254,000,000	$254,000,000
Spending Authority Offsets	1,000,000		
Budgetary Resources Available	**$205,000,000**	**$254,000,000**	**$254,000,000**
Administrative Expenses	19,000,000	19,000,000	19,000,000
Total Admin. DOJ/Claims Ct/HRSA	185,000,000	235,000,000	235,000,000
Reimbersable Program Activity (claims)	1,000,000		
Total New Obligations	**205,000,000**	**254,000,000**	**254,000,000**
Unobligated Balance	**-**	**-**	**-**

Budget Authority by Activity

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	$235,000,000	$235,000,000	$235,000,000
Administrative Expenses: HRSA Direct Operations	$6,477,000	$6,517,000	$6,477,000
Total Obligations	$241,477,000	$241,517,000	$241,477,000

Budget Authority by Object

	FY 2012 Appropriation	FY 2014 Estimate	Increase or Decrease
Insurance claims and indemnities	$235,000,000	$235,000,000	-
Other Services (25.2)	$6,477,000	$6,477,000	-
Total	$241,477,000	$241,477,000	-

Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2014 Amount Authorized	FY 2014 Pres. Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:				
Pre-FY 1989 Claims	110,000,000	---	110,000,000	---
Post-FY 1989 Claims	Indefinite	SSAN	Indefinite	$235,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):				
HRSA Operations	Indefinite	6,477,000	Indefinite	6,477,000

Appropriation History Table
(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
2001	---	---	---	---
2002	---	---	---	---
2003	---	---	---	---
2004	---	---	---	---
2005	---	---	---	---
2006	---	---	---	---
2007	---	---	---	---
2008	---	---	---	---
2009	---	---	---	---
2010	---	---	---	---
2011	----	----	---	----
2012	----	----	---	----

Vaccine Injury Compensation Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Claims BA	$235,000,000	$235,000,000	$235,000,000	---
Admin BA	$6,477,000	$6,517,000	$6,477,000	---
Total BA	$241,477,000	$241,517,000	$241,477,000	---
FTE	22	22	22	---

Authorizing Legislation – Public Health Service Act, Title XXI, Subtitle 2, Parts A and D, Sections 2110-19 and 2131-34.

FY 2014 Authorization ..... Indefinite

Allocation Method .....Other

Program Description and Accomplishments

The National Childhood Vaccine Injury Act of 1986 (the Act) established the National Vaccine Injury Compensation Program (VICP) to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. The Health Resources and Services Administration (HRSA) administers the VICP in conjunction with the Department of Justice (DOJ) and the U.S. Court of Federal Claims (Court). HRSA has been delegated the authority to administer Parts A and D of Subtitle 2. Consistent with this delegation, HRSA:

- Receives petitions for compensation served on the Secretary of HHS (the Secretary);
- Arranges for medical review of each petition and supporting documentation by physicians with special expertise in pediatrics and adult medicine, and develops recommendations to the Court regarding the eligibility of petitioners for compensation;
- Publishes notices in the Federal Register of each petition received;
- Promulgates regulations to modify the Vaccine Injury Table;
- Provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), composed of nine voting members, including health professionals, attorneys, and parents of children who have suffered a vaccine-related injury or death, and specified HHS agency heads (or their designees);

- Informs the public of the availability of the Program; and
- Processes award payments to petitioners and their attorneys for judgments entered by the Court, and informs the public of the availability of the VICP.

As of January 2013, over 3,150 families and individuals have been awarded compensation totaling over $2.58 billion since the Program's inception. FY 2008 through FY 2012 resulted in the largest outlays since VICP's inception, with over $777.9 million in compensation awards to more than 944 families and individuals. The Program filed 399 claims in FY 2012 (versus an average of 248 non-autism claims filed annually over the preceding ten years) and over 245 families and individuals were awarded compensation totaling $186.4 million, which is approximately $114 million more than the average amount of outlays from FY's 2002-2009. (Yearly outlay totals include payments for attorneys' fees and costs.)

In 2012, the Institute of Medicine (IOM) released its third consensus report on the epidemiological, clinical, and biological evidence surrounding adverse events associated with 12 vaccines covered by the VICP. The vaccines are varicella zoster, influenza, hepatitis B, human papillomavirus, measles-mumps-rubella, hepatitis A, meningococcal and tetanus-containing vaccines such as diphtheria and tetanus toxoids and acellular pertussis vaccines. Two previous IOM reports published in 1991 and 1994 led to the Secretary adding injuries/conditions to the Vaccine Injury Table. The Table provides petitioners with a presumption of vaccine causation (and entitlement to compensation), if certain legal requirements are met. Since the last set of IOM report-related Table modifications in 1997, nine vaccines have been added to VICP, but there has been no independent examination of the adverse events associated with the use of these vaccines. As mandated under the Act, the Secretary must consult with the ACCV and seek public comment before any modifications to the Table are made. In December 2011 and March 2012, the ACCV unanimously approved proposals to add more injuries to the Table. The proposals are currently under review by the Department.

The VICP performance measures are focused on the timely adjudication of vaccine injury claims and monetary awards. From FY 2005-2012, the target for the percentage of eligible claimants who were awarded compensation, but opted to reject awards and elected to pursue civil action has been zero percent, and the VICP has met its target each of these fiscal years.

In FY 2007, the VICP did not meet its target of 1,213 days for the average time to process claims due to petitioner and Court-driven delays in adjudicating claims. For the time period of FY 2007, the performance outcome was 1,337 days. However, the VICP target average time to process claims was successfully met for FY 2006, FY 2008, FY 2009, FY 2010 and FY 2011, with the FY 2011 result being 993 days. The target average time to process a claim was not met in FY 2012, with a result of 1,309 days average compared with a target of 1,300 days. This outcome was due, in part, because six claims which were filed back in 1999 went to judgment and were paid in FY 2012, several of which were multi-million dollar awards. This indicates the complexity and difficulty in these cases in determining damages and the development of life care plans.

The VICP has consistently exceeded its 86 percent target for the percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. In FY 2010,

the Rule 4(b) report deadline was met for nearly 96 percent of the cases that were deemed complete (which is slightly more than in FY 2009), and performance remained steady once again in FY 2011 at 96.6 percent. FY 2012 results were 94.7 percent, again exceeding the target of 86 percent.

Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2011, the average time to process a settlement was 9.4 days, compared to the target of ten days. During FY 2012, the VICP received a 76 percent increase in the number of claims from the previous ten-year average (a 226 claim average to 398 claims filed in FY 2012) and processed twice as many negotiated settlements over the last three fiscal years. This level of filed claims and settlements is expected to be maintained through FY 2014. Each DOJ settlement proposal requires the Office of General Counsel (OGC) review and preparation of a legal opinion for VICP. In addition, consultation with DOJ attorneys to clarify or amend elements in the settlement proposal is often required during the approval process. The FY 2012 result was an average of 6.6 days.

In FY 2011, VICP paid lump sum only awards within an average of 4.9 days, exceeding the eight day performance target. The FY 2012 lump sum only award processing average was 3.6 days.

The percentage of cases in which settlements were completed by agreement among the parties by DOJ within 15 weeks has remained at 100 percent since FY 2008, surpassing the 92 percent target.

Funding History

VICP Awards

FY	Amount
FY 2010	$193,906,900
FY 2011	$234,991,887
FY 2012	$235,000,000
FY 2013	$235,000,000
FY 2014	$235,000,000

Budget Request

The FY 2014 Claims Awards Budget Request is $235,000,000. The FY 2014 Request is equal to the FY 2012 Enacted level.

The FY 2014 Administrative Budget Request is $6,477,000. The FY 2014 Request is equal to the FY 2012 Enacted level.

The FY 2014 Request will fund the following:

VICP Claims Awards - The VICP awards payments to individuals or families of individuals, who have thought to have been injured, or have died, as the result of receiving a vaccine(s) recommended by the Centers for Disease Control and Prevention (CDC) for routine

administration to children. In FY 2013, HRSA estimates that $235,000,000 will be paid out of the Vaccine Injury Compensation Trust Fund (Trust Fund) for payment of Court-ordered awards for alleged vaccine-related injuries or deaths. These funding levels are necessary to account for potential outlays resulting from the processing of claims ordered by the Court that require medical reviews of increasing numbers of non-autism claims filed annually, medical reviews for certain autism claims, and compensation for injuries and attorneys' fees and costs. The significant increase in non-autism claims is primarily the result of the addition of the influenza vaccine to the VICP, which now accounts for approximately 50 percent of claims filed annually.

This Claims Award funding level will ensure adequate funds are available to pay awards allowing the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to pursue civil action.

Administrative Expenses - HRSA anticipates using $6,477,000 from the Trust Fund for administrative expenses to cover costs associated with the internal medical review of claims, external medical review of claims by outside consultants (including, where warranted, expert testimony to the Court), professional and administrative support to the ACCV, meeting specific administrative requirements of the Act, processing award payments, maintaining necessary records, and informing the public of the availability of the VICP.

Non-autism claim filings have increased significantly since FY 2008, primarily due to the addition of influenza vaccines in 2005. Over 400 claims were filed in FY 2010, 382 claims were filed in FY 2011, and 398 claims were filed in FY 2012, versus an average of 168 non-autism claims filed annually from FY 2000-2008. This upward trend is likely to continue with the February 2010 recommendation by CDC of universal use of influenza vaccines for all individuals over the age of six months. Further, claims alleging injury from the 2009 pandemic influenza H1N1 vaccine were initially filed with the Countermeasures Injury Compensation Program when it was a monovalent vaccine. However, starting with the 2010-2011 flu season, the H1N1 vaccine was made part of the seasonal influenza vaccine and now these claims are to be filed with the VICP.

The Administrative funding level will allow the utilization of medical experts to consult and provide testimony in defending claims on behalf of the Secretary before the U. S. Court of Federal Claims, targeting the number of claims compensated near FY 2011 levels.

Work on updating the Vaccine Injury Table following release in 2012 of the IOM's report on vaccines and adverse events have been initiated. Many stakeholders, including Congress have voiced interest and concern over keeping the Vaccine Injury Table in line with current science, a program objective that is included as a strategy in Goal 4 of the HHS' National Vaccine Plan. Work continues on updating the Table.

Beginning in 2001, parents began filing petitions under the VICP alleging autism (or autism spectrum disorder) from either measles-mumps-rubella (MMR) vaccine or thimerosal-containing vaccines, or from both. In 2002, the Chief Special Master of the Court created the Omnibus Autism Proceeding to adjudicate the thousands of claims that were expected. Over 5,600 cases were filed.

Omnibus hearings on entitlement to compensation for two theories of causation were held in 2007 and 2008. Three test cases were utilized for each theory and three special masters issued opinions on general causation, and causation in one of the three test cases for each theory. Theory 1 hearings looked at whether MMR vaccine, administered alone or in conjunction with thimerosal-containing vaccines, can cause autism or autism spectrum disorders, while the Theory 2 hearings determined whether thimerosol-containing vaccines can cause autism or autism spectrum disorders. Decisions in the six test cases in favor of the respondent were handed down by the U.S. Court of Federal Claims in 2009 and 2010. Appeals of the Theory 1 test cases were decided in favor of the respondent, and affirmed on appeal. Petitioners chose not to appeal the Theory 2 test case decisions.

In 2010, the Court began issuing orders to determine which petitioners want to pursue other theories of causation. Altogether, over 4,600 autism claims have been dismissed. Of the approximately 1,000 autism claims pending, it is uncertain how many will require medical reviews to determine if they were timely filed. Some petitioners are electing to pursue other theories, such as mitochondrial or metabolic disorders. Such claims will be tried on an individual basis and will require HRSA medical reviews and may require the use of medical experts for hearings.

HRSA will continue efforts to better publicize the VICP. HRSA has been criticized for not adequately promoting public awareness of the VICP. With this funding, HRSA will continue outreach efforts to better inform the public and health professionals about the VICP.

The FY 2014 Request should allow the Program to maintain current staffing levels to meet and exceed VICP-specific performance goals, which include measures 26.II.A.4 and 26.II.A.5. The former measure states "Decrease the average time settlements are approved from the date of the receipt of the DOJ settlement proposal." This measure has a target of ten days. The latter measure states "Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment." This measure has a target of eight days. These performance measures have been historically ambitious and appropriate funding levels are necessary for continued Program success in achieving these targets.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed.	FY 2012: 0% Target: 0% (Target Met)	0%	0%	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2014 President's Budget	FY 2014 +/- FY 2012
26.II.A.2: Average claim processing time.	FY 2012: 1,309 days Target: 1,300 days (Target Not Met)	1,300 days	1,300 days	Maintain
26.II.A.3: Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete.	FY 2012: 94.7% Target: 86% (Target Exceeded)	86%	86%	Maintain
26.II.A.4: Decrease the average time settlements are approved from the date of receipt of the DOJ settlement proposal.	FY 2012: 6.6 days Target:10 days (Target Exceeded)	10 days	10 days	Maintain
26.II.A.5: Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.	FY 2012: 3.6 days Target: 8 days (Target Exceeded)	8 days	8 days	Maintain
26.E: Percentage of cases in which case settlements are completed within 15 weeks.	FY 2012: 100% Target: 92% (Target Exceeded)	92%	92%	Maintain